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MEDICAL DEPARTMENT
UNITED STATES ARMY
IN WORLD WAR II

NOTE

This volume was written and edited under the direction and supervision of Colonel John Boyd Coates, Jr., MC, USA, and Colonel Arnold Lorentz Ahnfeldt, MC, USA, former Directors and Editors in Chief, The Historical Unit, U.S. Army Medical Service.

ROBERT S. ANDERSON,
Colonel, Medical Corps,
Editor in Chief.

U. S. Army. Surgeon General's Office

MEDICAL DEPARTMENT, UNITED STATES ARMY

NEUROPSYCHIATRY IN WORLD WAR II

Volume I

ZONE OF INTERIOR

Prepared and published under the direction of

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The Surgeon General, United States Army

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OFFICE OF THE SURGEON GENERAL

DEPARTMENT OF THE ARMY

WASHINGTON, D.C., 1966

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1419 SEP 67

Volume I

ZONE OF INTERIOR

Lulled in the countless chambers of the brain,

Our thoughts are linked by many a hidden chain;

Awake but one, and lo, what myriads rise!

—*Alexander Pope.*

MEDICAL DEPARTMENT, UNITED STATES ARMY

The volumes comprising the official history of the Medical Department of the United States Army in World War II are prepared by The Historical Unit, U.S. Army Medical Service, and published under the direction of The Surgeon General, U.S. Army. These volumes are divided into two series: (1) The administrative or operational series; and (2) the professional, or clinical and technical, series. This is one of the volumes of the latter series.

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Foreword

It is well recognized that the deprivations and hazards suffered by personnel in modern war produce emotional disorders in such large numbers as to constitute a major problem of military medicine and a principal cause of manpower attrition. However, during the preparatory and early phases of World War II, there was little appreciation of the magnitude of wartime psychiatric disorders. The considerable prevalence of incapacitating emotional reactions in military personnel of World War I, including "shell shock" and neurocirculatory asthenia, was known. But, then, it was widely believed by responsible professional and military authorities that such psychiatric cases were derived from so-called weaker personnel who were predisposed to situational stress. For this reason, major reliance was placed upon psychiatric screening at induction in order to exclude vulnerable individuals from entering military service.

As World War II proceeded, it became increasingly apparent that psychiatric screening had failed to prevent the appearance of vast numbers of emotional disorders. Further, battle experiences clearly demonstrated that combat psychiatric breakdown could originate from normal or previously stable personnel as well as from those of weaker predisposition. Thus, the Army Medical Department was confronted with the difficult task of dealing with an unprecedented incidence of psychiatric casualties from both combat and noncombat sources for which there had been little preparation in either organization or methodology or training psychiatric personnel. The struggle to overcome these handicaps and the eventual establishment of effective programs of prevention and treatment present an epic achievement in military medicine and is the subject of this history of neuropsychiatry in the U.S. Army in World War II.

In this first volume of the history is recorded the administrative and professional frustrations, failures, and successes as they occurred in the Zone of Interior. The second volume, now well along in preparation, will contain an account of neuropsychiatric problems in oversea theaters, both combat and noncombat.

Despite the vicissitudes that were encountered, military psychiatry gained immeasurably from the experiences of World War II. As a result, psychiatry became a major component of the Army Medical Service and rendered important contributions to "conserving the fighting strength" during and since the Korean War. Perhaps even greater gains were made by civilian psychiatry as evidenced by its explosive expansion following World War II. The exigencies of war stimulated those concepts and practices which fostered the early and widespread treatment of mental disorders. Indeed, the current nationwide movement for the establishment

of community mental health centers can be traced to techniques developed by training camp consultation services and by forward combat psychiatric units wherein it was demonstrated that emotional illness was most effectively treated when such treatment was accomplished as soon as possible and as near as possible to the site of origin.

Military service also made a major contribution to the professional growth of psychiatrists on active duty during the war. With their experience broadened, they were better equipped, upon return to civil life, to develop further their private, institutional, and teaching practices. Moreover, the increased Army needs for psychiatrists required the utilization and training of large numbers of general medical officers in psychiatric assignments. Most of these physicians became interested in this specialty and sought further training upon their return to civilian life. Thus, the heightened wartime requirements for psychiatrists provided many of these urgently needed specialists to satisfy, at least partially, the huge unmet needs for mental health care in the civilian community.

In this volume, the editors have wisely included a summary chapter, "Lessons Learned," thus making available in one small section the essentials of the hard-won knowledge gained by military psychiatry in World War II. A similar summary final chapter is planned for the second volume. With this information so readily available, there can be little excuse for repetition of error in future wars, should they occur.

Again, as in previous volumes, I wish to extend to my staff of The Historical Unit who are helping me in preparing these histories and to the authors, technical editors, and reviewers of manuscripts my very special praise and gratitude for their contributions. Particularly do I wish to acknowledge the conscientious and dedicated work performed on this volume from 25 February 1957 to 28 February 1963 by Lt. Col. Robert J. Bernucci, MC, USA (Ret.), as special project officer and the initial editor, and by his successor, Col. Albert J. Glass, MC, USA (Ret.), who picked up so ably where Lieutenant Colonel Bernucci left off.

I am also indebted to the Advisory Editorial Board for Neuropsychiatry for its wise guidance and support in this project. In this regard, I am especially saddened by the deaths of three of its distinguished members as this volume goes to press, Dr. Frederick R. Hanson, Dr. William C. Menninger, and Dr. Manfred S. Guttmacher, all widely known for their valuable contributions to neuropsychiatry. May this volume serve an additional purpose as a fitting memorial to them.

LEONARD D. HEATON,
Lieutenant General,
The Surgeon General.

Preface

An official compilation of the History of Neuropsychiatry in World War II was anticipated long before the termination of hostilities. Army Regulations No. 345-105 (30 June 1928) provided for the continuous recording of military history, and subsequent changes thereto, from 1940 to 1943, stressed the inclusion of wartime activities. Therefore, with this task in mind, during and for some time after World War II, related materials and documents were accumulated and stored by responsible members of the Surgeon General's Office and the staff of the Neuropsychiatry Consultants Division. Key personnel and many of the assigned consultants were periodically brought into the division to record their experiences before they were deployed elsewhere, or released from the Army. Their contributions form much of the basic material from which this volume has evolved. In June 1945, Brig. Gen. William C. Menninger, MC, developed an original outline for this history. A few months later, after several revisions and changes in format, Lt. Col. Malcolm J. Farrell, MC, produced the outline which was generally accepted at the time and followed, but with little success, for attempts to complete the work failed, until 1957 when the project was again resumed.

The reason for the failure was an assumption that such a history could be written with part-time leadership. While an individual author could take time out of a busy schedule to write a particular chapter, the coordination and completion of the entire task required the continuous effort, organization, and single-minded dedication by some one person or agency. Even attempts to engage an individual for 3 months or even a year had been unsuccessful.

Upon viewing the inaction of previous years, Col. Albert J. Glass, MC, one of the editors of this volume, upon assuming the position of Chief Neuropsychiatric Consultant to The Surgeon General, in the latter part of 1956, met with Col. John Boyd Coates, Jr., MC, then Director, The Historical Unit, U.S. Army Medical Service, and both reached the decision that it was necessary to assign a full-time project officer to The Historical Unit for at least 3 years. This plan was broached to The Surgeon General and was accepted. Lt. Col. Robert J. Bernucci, MC, the other editor of this volume, was selected and assigned as the Project Officer, in February 1957. An Advisory Editorial Board for Neuropsychiatry was appointed on 5 August 1957 and met for the first time on 27 September 1957. Authors were selected, a new outline for an administrative and clinical presentation of neuropsychiatry was prepared, available manuscripts were reviewed, and slowly but steadily the history began to take form.

It soon became apparent, however, that there could be no realistic separation between administrative and clinical aspects of wartime psychi-

atry. Therefore, discarding this approach, the old history outline of Menninger and his associates was resurrected. Other relevant data which had been accumulated in the previous decade were incorporated and a revised outline format was produced and accepted by the Advisory Editorial Board.

The Advisory Editorial Board selected 35 major authors, who were involved in World War II neuropsychiatry, and The Surgeon General invited them to participate in the writing of the history. All but one, who was ill in a hospital at the time, accepted. This group included members of the Advisory Editorial Board who assumed the duties of key authors or monitors for the various sections of the history. Since then, the list has been expanded to approximately 70 authors, coauthors, collaborators, and monitors. Several hundred World War II psychiatrists and neurologists in response to personal requests contributed anecdotes and experiences, reference material, reprints, and photographs. Every effort toward proper attribution for the material used has been made in this volume.

As this history is a product of many authors, some duplication was inevitable. It was necessary for each author to establish a background to relate the events of World War II as it concerned his particular area of endeavor. To have ruthlessly removed all such duplication would have made unintelligible many of the chapters as individual accounts of a particular sphere in World War II neuropsychiatry.

Another important consideration must be noted. The authors, as persons who participated in World War II, having their own viewpoints and judgments of events, were given considerable freedom in their viewpoint but at the same time assumed responsibility for their work. Many controversial areas, therefore, are presented in which judgments of individual authors may be contrary to other opinions. From an editorial standpoint, it was not deemed necessary to point out each and every possible area of controversy and difference, then and now. Some brief editorial comments, pointing out inconsistencies and contradictions have been made, but this was by no means done in all instances. Undoubtedly, readers will find many statements with which they take an opposite view. However, history is not designed to settle issues but rather to present adequate data of past events and permit readers to draw their own conclusions.

After review of the collected manuscripts, the Advisory Editorial Board found variable uses of the words "neuropsychiatry" and "psychiatry" by different authors. They decided that the word "neuropsychiatry" should be used where it was demanded by historical necessity, as in formal titles and official designations of units and their functions, and where this word most accurately fitted into the general or historical context of a passage. However, the word "psychiatry" was favored when the specific context called for this more restrictive term which was less ambiguous and more in keeping with current usage at the time of this writing.

From the many authors involved, it was possible to cover every facet of the history by those who actually experienced it. At first, some found it difficult after a lapse of years to stimulate old memories, to revise their old manuscripts, or to write anew; some even may have preferred not to reactivate painful experiences; some verbalized freely; others may have found it tedious; some wrote in one style and some in another. To keep continuous contact with all authors, to provide them with source material, and to prod and encourage some writers who were understandably engaged in full-time civilian pursuits were some of the tasks of the Project Officer. All finished manuscripts were eventually assembled and presented insofar as possible within the limits of space imposed by the publication which was authorized. Unfortunately, much had to be deleted from almost every manuscript. However, every effort was made to retain the major topics stressed by each author. The editors can only express their regrets that the full manuscripts could not be reproduced.

There were many other factors involved in the production of this historical account. The Project Officer became the central or pivotal point for all contributors. Correspondence was voluminous. Thousands of pages of reference material had to be unearthed, reviewed, reduplicated, and shipped to the many writers, and thousands of photographs were screened to uncover a few suitable prints for this volume.

It cannot be denied that there were marked differences between World War I and World War II. During the interval between the wars, our youth was impressed with the theme that war was wrong. With the declaration of World War II, there were no spontaneous rallies, enthusiastic war slogans, or new martial songs to stimulate the will to fight, as there had been in World War I. In World War II, environmental pressures, both in the United States and abroad, were multiplied and stresses increased in an army so vast and widely distributed. The increased efficiency and lethality of newer weapons surpassed that of the First World War. World War I lasted 1½ years and was fought in only one theater. World War II lasted 4 years and was fought in many theaters all over the globe.

In World War I, psychiatry seemed better organized at the outset and was able to progress to maximum efficiency more quickly. In World War II, psychiatry started more slowly, progressed more slowly, and yet, despite many problems and wider coverage, it actually accomplished more than could be claimed for World War I, although admittedly more time was required. Millions more people were in the service during the Second World War and they required many more medical personnel, including neuropsychiatrists who were always in short supply. Although it took 10 years to publish the neuropsychiatric history of World War I, it should be recognized that the wider scope, the longer duration, and the multiple theaters of operations required more time to be expended in the production of the neurospsychiatric history of World War II. It must be remembered that we fought the Korean War in the interim, which also contributed to the delay.

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The editors wish to express their sincere thanks to the medical officers who made the material for these chapters available and to the distinguished authors who have written them. In addition, thanks are due to the entire Advisory Editorial Board for its constant support.

Grateful appreciation is due Col. Arnold Lorentz Ahnfeldt, MC, who succeeded Col. John Boyd Coates, Jr., MC, as Director and Editor in Chief, The Historical Unit, U.S. Army Medical Service, and who continued, in the manner of Colonel Coates, to guide this project and give frequent encouragement and experienced advice when it was needed.

In particular, the editors and authors are greatly indebted to a number of persons whose contributions made possible this final product:

To Mr. E. L. Hamilton, Chief, Medical Statistics Division (now Agency), Office of The Surgeon General, and particularly to Dr. Bernard D. Karpinos, Special Assistant for Manpower Studies, in the Medical Statistics Agency. The basic medical statistical data relating to the various phases of the neuropsychiatric problem, presented in the various chapters of this volume, unless otherwise indicated, were provided or reviewed by these members of the Agency, especially by Dr. Karpinos who also provided other essential data for inclusion in this volume. The data furnished by the Medical Statistics Agency are based on tabulations of the individual medical records, except for those in which the source is otherwise specified.

To Mrs. Genevieve Comeau, General Reference and Research Branch, The Historical Unit, who devoted many hours and days, in that branch and in other archival repositories, searching for material requested or otherwise needed by the many authors. Unfortunately, ill health necessitated Mrs. Comeau's resignation; her work was most ably continued by Mrs. Claire M. Sorrell.

To Mrs. Hazel G. Hine, Chief, Administrative Branch, The Historical Unit, and her competent staff in both the Administrative Branch and the Reproduction Section of that branch, who patiently cooperated with the many tedious tasks involved in the typing and reduplication of old tattered and frayed documents, scattered bits of information, manuscript drafts, and finally, the finished manuscripts.

To Mrs. Elaine R. Stevenson, Editor (Printed Media), of the Editorial Branch, The Historical Unit, who ably assisted in the publications editing and indexing for the volume.

And finally, to Miss Rebecca L. Duberstein, Chief, Editorial Section, Editorial Branch, The Historical Unit, who, by her knowledgeable comments and suggested text revisions for correction and clarification, enhanced the presentation of many of these chapters.

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Prologue

In relating the history of neuropsychiatry in World War II, it should be understood at the outset that the problems of psychiatry were basically the problems of mobilization, manpower, selection, training, and utilization of miltary personnel, as well as those of industrial mobilization and coordination with powerful civilian agencies. Although psychiatrists could be expected to do their part in the war effort, they could not deal completely with the vast problems mentioned, and it may be of interest to physicians to read about some of the processes which determined their workload.

It is not easy to picture the scene as it seemed to those of us who lived it. Any brief statement is an oversimplification, and every observer is limited by his necessarily curtailed personal experience and his own personal bias as well as by those inevitable distortions of memory which occur during the years which have passed. However, the documentation which is available enables even a biased observer to cite evidence for major trends. Unfortunately, the official language of both published regulations and unpublished reports does not convey sufficiently the strength of the rejection of psychological problems in the Army from the very beginning. Informally and privately, many Regular Army officers of all branches would express concern over the so-called psychiatric problem, which was really one facet of the need "to conserve fighting strength." Officially, however, particularly in the higher ranks, there was no realistic appraisal and willingness to take active responsibility for Army-wide correction of the difficulties, as seen by Brig. Gen. Elliot D. Cooke, USA; by Maj. Gen. Frederick H. Osborn, Director, Information and Education Division, War Department, in his survey; or by the Doolittle Board. The attempts by the Information and Education Division, in 1943 and 1944, to improve morale were, at best, rather piecemeal, half-hearted, and inadequate to the task.

It is also regrettable that few published regulations and reports reflect the dissatisfactions and failures inherent in any given situation. By the very nature of army organization and human ambition, it is essential that deficiencies are minimized or denied. An officer's pride and his group loyalties often prevented candid appraisals. Only in some contemporary diaries does one get the full flavor and intimate detail of the operations in question. Furthermore, it is only too well known that regulations are interpreted variously, if they are utilized at all. This was the case with many Army Air Forces, Army Ground Forces, and some service command commanders. They had vigorous defenses against a better attitude for prevention and treatment of those soldiers in need of help. Although

psychiatrists were often well regarded as individuals, they were usually accepted as a rather painful, necessary evil which it would be better to do without. The psychiatrists had few defenses in those posts where there was active animosity against them.

Basically, as any student of history knows, the major factors determining our military policy are the attitudes of the people of the United States. Through their elected representatives to Congress, they determine what our military strength and goals should be. Congress in turn determines what the War Department should do in preparation for war and exercises power on the conduct of a war. Without firm instructions from Congress, particularly with regard to a coordinated foreign policy and adequate preparation for contingencies as they present themselves, the Military Establishment is almost reduced to impotence until asked to produce a fighting force overnight. It is a fact that in none of our eight major wars have we been prepared, with resulting confusion and waste.

The central problem was the proper use of manpower in all of its ramifications. Men with good morale are ultimately more important in a war effort than material, as stated by Gen. George C. Marshall, but despite the well-recognized importance of this principle, it seemed as if our most glowing successes were in the field of materials, and our most glaring failures in the management of men. Only gradually under severe pressures both at home and overseas did the Military Establishment begin to deal realistically with the human problems of the "lost divisions," even in such simple procedures as malarial control. The deeper prejudice against dealing realistically with the emotional problems of military personnel was never overcome completely.

The words of General Osborn, in his official report to the Chief of Staff, 16 November 1945, are a reminder of the basic issue: "War is no longer a game to be played by a guild of professional soldiers, but a business which involves mobilization of all the resources, human and otherwise, of the Nation."

However, the War Department, acutely conscious of the desperate need of proper and ample supplies, apparently gave priority to this endeavor. Gen. Brehon B. Somervell, Commanding General, Army Service Forces, stated the alternative clearly: "Broken armies can reform to fight again, while broken lines of communication and supply of all the nations are too long to be quickly replaced." It will require military historians with greater mastery of the problem than the author to render a judgment on this question. This review is made to describe the facts as we saw them, and hope future planners can do better.

It is well known that the mission of the Medical Department of the Army is to conserve manpower and maintain the health of the Army. The vicissitudes of the Medical Department in the effort to accomplish these missions were particularly strong in the psychiatric area because medical and psychiatric channels were employed to control the size of the Army and thus strongly affected our total manpower.

The neuropsychiatrists who were charged with the responsibility of

discharging either sick or ineffectual soldiers found themselves at a disadvantage from the beginning of the war because some of their seniors in civilian medicine and psychiatry and the War Department had placed too much emphasis upon initial screening at induction and had the mistaken belief that, for all practical purposes, manpower was unlimited. Only after a large number of soldiers had been separated during 1942–44 was serious attention given to developing methods to prevent a large percentage of medical and administrative discharges by improved leadership, personnel policy, and motivation. Neuropsychiatrists were only one part of the entire organization but a critical one. Some commanders even blamed them for the huge loss of manpower until an Inspector General's report in December 1944 definitely placed the responsibility upon command: "Actually, the majority of these cases are not psychoneurotic conditions because medical officers wish to make patients out of them but because the line officers have been unable to make soldiers out of them." Only gradually were means found to retain soldiers who could perform duty and yet permit separation of those who could not or would not do so.

The problem of conserving manpower has always been a traditional one in the Army but was complicated in this war by the unprecedented and enormous size of the Army for which there was no adequate planning, the rapidity with which this size was attained, and the unexpected losses due to poor motivation and personnel policies which accompanied the accelerated mobilization. Other volumes in this series tell in greater detail the various facets of command policy, personnel practices, and administrative decisions which helped to shape the events recorded here.

There were many misunderstandings and controversies at all levels, although most service personnel at lower levels did their best to cooperate and help each other. From the record which follows, it can be seen that The Surgeon General did all in his power to give strong support to all medical officers to practice the best medicine possible, and succeeded to a remarkable degree in keeping the level of medical care very high in spite of many handicaps, including the crucial loss of power of classification, promotion, and assignment. Although The Surgeon General was responsible for the activities of the Medical Department and the health of the Army, he was unable to exert any command functions beyond a limited sphere because these had been given to the General Staff; to Headquarters, Army Service Forces; to Headquarters, Army Ground Forces; to Headquarters, Army Air Forces; and to the service commands. Until late in the war, The Surgeon General did not have direct access to the Chief of Staff or the General Staff. Consequently, it was not until 1945 that policies and practices for the best care of the troops were able to be published and implemented.

In view of these difficulties, all personnel associated with the Medical Department can be proud of its achievements under adverse circumstances. Their loyalty and devotion to duty has to be recognized by the other services and combat arms who always found medical personnel at their side

wherever they might be. Both the Regular Army and civilian physicians earned these tributes and deserve commendation for their efforts.

HENRY W. BROSIN,
Colonel, MC, USAR.

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Part I

INTRODUCTION

CHAPTER I

Army Psychiatry Before World War II

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HISTORICAL NOTE

Awareness of mental disorder as a major military medical problem came about gradually, beginning in the latter half of the 19th century and developing parallel with the evolution of modern psychiatry. Little was written of psychiatric illness as such in the large six-volume official "Medical and Surgical History of the War of the Rebellion." [1] Only 2,410 cases of insanity were recorded from the several million combat and noncombat casualties of that conflict. However, also included were 5,213 cases of nostalgia defined as "a species of melancholy, or a mild type of insanity, caused by disappointment, and a continuous longing for the home." [2] In addition, J. M. Da Costa,[3] an Army physician in the Civil War, studied so-called irritable and exhausted heart disorders out of which he described functional heart disease, many cases of which were apparently similar to the syndrome of neurocirculatory asthenia of World War I.

With the passing decades came increasing knowledge of mental disorders and greater uniformity of psychiatric nomenclature and classification. Medical officers of various countries noted an excessive prevalence of mental disease in military personnel, particularly in time of war. An increase in mental cases was reported during the Franco-Prussian War, the Spanish-American War, the Boer War, and the Russo-Japanese War.[4] Rates of mental illness during these conflicts are given as ranging from 2 to 3 per 1,000 troops per annum. In the Russo-Japanese War (1904–6), an organized program was developed, for the first time, in which mental illnesses of military personnel were treated by specialists in psychiatry. Because the increased mental cases overtaxed the capability of the Russian Army Medical Service, the problem was turned over to the Red Cross Society of Russia which established psychiatric treatment facilities in

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[1] Medical and Surgical History of the War of the Rebellion. Medical Volume. Washington: Government Printing Office, 1870, pt. I, vol. I, p. 639.

[2] Hall, J. K., Zilboorg, Gregory, and Bunker, Henry Alden (editors): One Hundred Years of American Psychiatry. Published for the American Psychiatric Assoc., by Columbia Univ. Press, New York, 1944, p. 374.

[3] Medical and Surgical History of the War of the Rebellion. Medical Volume. Washington: Government Printing Office, 1888, pt. III, vol. I, pp. 862–866.

[4] (1) Neuropsychiatry and the War. National Committee for Mental Hygiene, New York, 1917, p. 140. (2) Read, C. S.: Military Psychiatry in Peace and War. London: H. K. Lewis & Co., 1920.

cities near the front as well as in rear home areas. Richards [5] reported that the fear of the harmless gas bombs of the Japanese produced one form of psychosis. Depressive syndromes, general paresis, and alcoholic psychosis were frequent. Indeed, it was postulated that the development of organic psychoses was hastened or precipitated by the strain of wartime conditions.[6]

Problems of Diagnosis

It is evident that before World War I the incidence of psychoses mainly was recorded. The concept of neurosis was little appreciated during these years, and thus the diagnosis of psychoneurotic disorders, except for neurasthenia and hysteria, was seldom made. Salmon [7] pointed out that these higher rates of insanity in military personnel during war were due in part to the failure to recognize "the real nature of severe neuroses." He offered as evidence repeated instances in World War I of many soldiers, suffering from undoubted war neurosis, who were evacuated as psychotic or insane. While such errors in diagnosis are quite probable, particularly in combat when the intensity of acute psychiatric symptoms may temporarily reach psychotic proportions, it is pertinent to note that rates of psychotic disorders of 2 to 3 per 1,000 troops per annum prevailed in World War II and in the Korean War as well as in World War I. This represents only a small increase over rates of psychoses of military personnal during peacetime (between 1 and 2 per 1,000 per annum). A more rational explanation for the relatively modest rise of psychotic disorders during war lies in the high proportion of personnel new to military service. Since the majority of psychotic disorders become evident in the first 2 years of service, whether in peace or war, it is likely that large increments of new personnel were mainly responsible for the somewhat higher figures of wartime mental illness.

Although there is a minor rise in the psychosis rate during any war, a major increase in the incidence of neurotic disorders was observed, starting with World War I. Whether the war neuroses were not recognized in earlier years, owing to lack of psychiatric sophistication, or whether they simply did not occur because of the relatively low destructive power of weapons before World War I, cannot be answered. However, the total psychosocial matrix in any war must be kept in mind. Morale, motivation, and the quality of leadership are always important factors. All armies had deserters, malingerers, defaulters, and "escapists." The more modern armies had fewer roads of "escape" which would permit individual adaptation. Also, stress and strain were more constant and prolonged.

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[5] Richards, R. L.: Mental and Nervous Diseases in the Russo-Japanese War. Mil. Surgeon 26: 177–193, February 1910.

[6] Neuropsychiatry and the War. National Committee for Mental Hygiene, New York, 1917, pp. 220, 223.

[7] *Ibid.*, p. 499.

Army Psychiatry, 1900-17

In the early years of the 20th century, psychiatry in the U.S. Army made slow progress. As in previous decades, cases of so-called insanity were either discharged from the service or were transferred to the Government Hospital for the Insane at Washington, D.C. (now St. Elizabeths Hospital). However, the desirability of having medical officers more equipped to handle such cases was becoming increasingly recognized. Dr. William A. White, the Superintendent of the Government Hospital for the Insane, gave a series of lectures on psychiatry each year to classes of the Army and Navy Medical Colleges. It also became the custom to detail one medical officer each from the Army and the Navy to the Government Hospital for the Insane to study mental diseases for a 2-year period. The incidence of insanity in Army enlisted personnel in the decade of 1901–11 continued at the usual rate of 1 to 2 per 1,000 troops per year.[8]

Beginning on 1 January 1912, insanity as a diagnostic entity was discarded in favor of "mental alienation" which included not only dementia praecox and other functional and organic psychoses but also defective mental development, constitutional psychopathic states, hypochondriasis, and nostalgia. Excluded from mental alienation were such neurotic afflictions as neurasthenia and hysteria, also alcohol and drug addiction. A prompt result of this change was an increase in the reported frequency of mental disease (mental alienation) to rates of 3 to 4 per 1,000 troops.[9] According to Maj. Edgar King,[10] the percentage of disability discharge for mental alienation in 1912 (20 percent) was higher than any other cause and would have been larger if hysteria or neurasthenia were included. It is noteworthy that mental illness has continued to be the leading cause of medical discharge even up to the present writing (1965), with dementia praecox (schizophrenia) as the single most important disease from the standpoint of disability.

WORLD WAR I

From the earliest fighting of World War I, in 1914, there appeared accounts of a new psychiatric disorder termed "shell shock," which was of such prevalence as to constitute a major military medical problem.[11] It seemed that warfare which had reached new heights of destruction and terror with weapons of high lethal and explosive power, grinding trench fighting, fatigue, and exposure had evoked a novel psychiatric entity. In time, the Allied Medical Services came to understand that "shell shock" was a psychological disorder and not due to brain injury from the airblast

[8] Annual Reports of The Surgeon General, U.S. Army. Washington: U.S. Government Printing Office, 1902—12.

[9] Annual Report of The Surgeon General, 1913.

[10] Neuropsychiatry and the War. National Committee for Mental Hygiene, New York, 1917, p. 221.

[11] *Ibid.*, pp. 225, 237.

of high explosives. Concurrently, trial and error treatment efforts by French, Italian, and British psychiatrists and neurologists clearly demonstrated as early as 1915 and 1916 [12] that a majority of the so-called war neuroses could be salvaged for duty by providing care near the front. Conversely, evacuation of such cases to rear hospitals produced fixation of symptoms and chronic disability.

National Committee for Mental Hygiene.—News reaching the United States of the new and dramatic psychiatric syndromes of combat excited much comment and discussion in medical and psychiatric circles. Particularly concerned was the National Committee for Mental Hygiene, a young and vigorous organization composed of prominent laymen, physicians, and psychiatrists and dedicated to the prevention and treatment of mental illness. Under the leadership of Dr. Thomas W. Salmon, who had been appointed medical director in 1915, the Committee made its services available to the Army Surgeon General to aid in planning for the management of psychiatric disorders in the event the United States became involved in the war.[13] Members of the Committee visited Army medical facilities mainly at posts along the Mexican border and in Canada and England, to obtain firsthand information on the current status and needs of psychiatry in the U.S. Army and on the experiences of the Allied Medical Services with psychiatric casualties. Based upon these visits, comprehensive recommendations for establishing a psychiatric program for the U.S. Army were made to The Surgeon General, which in the main were accepted.[14]

With the entry of the United States in the war, the War Work Subcommitte of the National Committe for Mental Hygiene became actively engaged in furthering the military psychiatry effort, which included the recruiting and training of psychiatrists, neurologists, psychiatric nurses and attendants, and social workers. Committee members Dr. Pearce Bailey and Dr. Thomas W. Salmon were commissioned and given responsible psychiatric assignments. Major Bailey in the United States and Major Salmon in the American Expeditionary Forces implemented the organization and operation of the Army psychiatry program at home and overseas. An account of this program and its results has been well documented in volume X of the "Medical Department of the United States Army in the World War."

LESSONS OF WORLD WAR I

Much was written of the lessons of psychiatry learned in World War I, particularly during the period of mobilization and early phases of World

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[12] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, pp. 507–512.

[13] Hall, J. K., *et al.*, *op. cit.*, p. 385.

[14] The Medical Department of the United States Army in the World War, vol. X, pp. 5–13; 489–496.

War II. Prominent civil and military medical authorities [15] pointed out that World War I had demonstrated the necessity and feasibility of psychiatric screening in eliminating overt and covert mental disorders prior to entry in the military service. Emphasized by these authorities, based upon the experience of World War I, was the inability of emotionally unstable or otherwise psychiatrically vulnerable persons to absorb training profitably, to tolerate stress, or otherwise to make any useful contribution to the military effort. Also cited as further evidence for the thorough screening out of even potential psychiatric problems was the high cost of mental disorders in war that included their deleterious effect on other soldiers, the increased requirements of medical personnel and facilities to care for these problems, disability pensions, and other veterans' benefits.

However, it became evident during World War II that psychiatric screening at the induction level was neither an effective nor practical procedure.[16] The incidence of psychiatric disorders in World War II was two to three times that of World War I despite the fact that rejections for psychiatric reasons were five to six times greater than those of World War I.[17] It is, therefore, a matter of some historical and professional concern to understand the reasons why psychiatric screening presumably produced such excellent results in World War I and was a failure in World War II. One can argue that the psychiatrists of World War I were more skilled in the techniques of screening than were their counterparts in World War II. But this is an unlikely possibility in view of the advances in psychiatry during the two decades between the wars. Indeed, the increased knowledge and sophistication of the World War II psychiatrists may well have been a crucial factor in accounting for differences in psychiatric screening of the two wartime periods.

Psychiatrists of World War I, mainly trained and experienced in institutional practice and following a model of descriptive or Kraepelinian psychiatry, identified and eliminated individuals who manifested obvious symptoms of mental disease and defect. Only 2 percent of recruits were rejected for neuropsychiatric reasons in World War I, which included epilepsy and organic central nervous system diseases, as well as functional disorders. The neuroses accounted for only 16.5 percent of rejections as compared to 31.5 percent for mental deficiency, 11.4 percent for psychoses,

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[15] (1) Hillman, C. C.: Medical Problems Encountered in Military Service. Ann. Int. Med. 13: 2205–2211, June 1940. (2) Editorial. With Emphasis on the Word Selective. Mil. Surgeon 87:265–266, September 1940. (3) Bowman, K. M.: Psychiatric Examination in the Armed Forces. War Med. 1: 213–218, March 1941. (4) Sutton, D. G.: Naval Psychiatric Problems. Am. J. Psychiat. 97: 225–275, September 1940. (5) Porter, W. C.: Military Psychiatry and Selective Service. War Med. 1: 364–371, May 1941. (6) Pratt, J. H.: Psychiatric Factors in Medical Examination. War Med. 1: 358–363, May 1941. (7) Davidson, H. A.: Mental Hygiene in Our Armed Forces. Mil. Surgeon 86: 477–481, May 1940.

[16] Glass, Albert J.: Psychosomatic Medicine. *In* Medical Department, United States Army. Internal Medicine in World War II. Volume III. Infectious Diseases and General Medicine. [In preparation.]

[17] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 338–347.

and 8.9 percent for constitutional psychopathic states.[18] The modern concept of personality development was not widely known or accepted at that time, although Salmon and others were familiar with the teachings of Sigmund Freud.

Conversely, psychiatrists in World War II, and indeed the prevailing culture, were much more conversant with neurotic disorders and the probability of this or that vulnerable personality becoming decompensated or disabled when exposed to stress. Thus, it may be said that psychiatric screening in World War I accomplished, in the main, elimination of overt mental disease and defect. In World War II, however, the screening procedure involved the rejection of covert or potential emotional problems in individuals with so-called character neurosis or other personality weaknesses, as well as with the more obvious psychiatric disorders. Unfortunately, this procedure proved to be inaccurate and impractical for predicting which type of personality would succumb to "stress," particularly when performed by a rapid examination.

There are other considerations which bear upon this question. First, data of World War I do not demonstrate the validity of the screening process despite the strong convictions of Bailey, Salmon, and other World War I psychiatrists. Second, in World War II, military personnel were exposed to weapons of greater destructive power and to more severe environmental and other deprivations over a longer period of time than in World War I. Morale factors including quality of leadership, training, and basic motivation from home or indoctrination acquired in the Army may also have played an important role. In effect, the conditions of the two wars were different in both quantity and quality of hardship and terror. Despite the foregoing, one cannot escape the conviction that the lesson of psychiatric screening of individuals learned in World War I may have been sound; namely, that gross or overt mental disorder or defect can and should be eliminated at induction.

PSYCHIATRY, 1920–30

The experiences of psychiatry in World War I had a lasting effect on Army medical practice. Following the cessation of hostilities and the return of the Army to a small peacetime force, psychiatric treatment facilities which had been established during World War I were maintained and became a regular component of military medical care. These clinical facilities, consisting of open and closed wards, consultation services, and outpatient activities, functioned as a section of the medical services at Walter Reed General Hospital, Washington, D.C., Letterman General Hospital, San Francisco, Calif., William Beaumont General Hospital, El Paso,

[18] (1) The Medical Department of the United States Army in the World War, vol. X, p. 157. (2) Appendix A, "Disqualifications and Discharges for Neuropsychiatric Reasons, World War I and World War II (A Comparative Evaluation)," p. 761.

Tex., and Fitzsimons General Hospital, Denver, Colo.; at the Station Hospital, Fort Sam Houston, Tex.; at Sternberg General Hospital, Manila, P.I.; and at Tripler General Hospital, T.H. As before the war, selected career medical officers were assigned to St. Elizabeths Hospital for 2 years of psychiatric training. In the first decade after World War I and to a lesser extent in the following years, the psychiatric sections of Army hospitals also served as receiving and treatment facilities for veterans with acute mental illness.

Incidence of Mental Disorders

Rates of hospitalization for mental disorders in Army personnel during the postwar period (1920–30) ranged from 11 to 12 per 1,000 men per year.[19] These rates included admissions for "mental alienation" (dementia praecox, manic depressive psychosis, general paresis, alcoholic and other organic psychoses, mental deficiency, constitutional psychopathic states, hypochondriasis) and various neurotic disorders (hysteria, neurasthenia, psychasthenia, psychoneurosis, neurocirculatory asthenia). The incidence of psychotic disorders during this period was from 2 to 3 per 1,000 per annum. Excluded from the preceding mental disease categories were admissions for neurological diseases, drug addiction, and acute and chronic alcoholism. Admissions for alcoholism alone during this 10-year period were from 7 to 8 per 1,000 per annum, a marked decrease from rates of approximately 16 per 1,000 per annum for alcohol admissions in the decade prior to World War I (1907–16) before the establishment of the National Prohibition Act. That mental disorders constituted a major medical problem in the postwar era is indicated by the following data:

1. Suicide was the leading cause of death in military personnel in this decade (over 0.5 per 1,000 strength per annum).

2. Mental disorders as a class were the largest cause for medical discharge with a rate of 6 to 7 per 1,000 strength per annum, which indicated that more than one-half of the admissions eventuated in discharge.

3. Dementia praecox was the leading single disease cause for medical discharge (2 to 3 per 1,000 strength per annum).

4. In general, mental disorders, excluding alcoholism and drug addiction, were first as a cause for discharge, fifth or sixth as a cause for hospital admissions, and third or fourth in producing loss of duty time for medical reasons.

5. Mental disorders were the leading cause for medical evacuation from oversea stations.

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[19] Annual Reports of The Surgeon General, 1921–31.

Psychiatric Screening

Army medical authorities were well aware that nervous and mental disorders constituted a large and important segment of military medical workload. Annual reports of The Surgeon General during this period made frequent references to the extent and seriousness of mental disorders and manpower loss presented by this group. Major emphasis for the existence of the problem was placed upon errors in the recruitment of mentally unfit soldiers as follows:

> Nervous diseases alone caused a loss of more than one-third of the total days [lost], averaging 71.8 days per case. When one considers the cost of enlisting, transporting, equipping, feeding, hospitalizing, and paying such men, the majority of whom probably rendered little if any efficient military service, and many of whom no doubt when not in the guardhouse or hospital were an actual liability rather than an asset to their organization, the very great expense entailed by the enrollment of them is apparent.[20]
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> It is extremely regrettable that the lessons learned during the war regarding neuropsychiatric conditions are not being used in the selection of recruits. That this is not being done is evidenced by the large number of candidates with neuropsychiatric conditions which are passed by recruiting officers.[21]

It is evident that there existed then, as later in the World War II era, a conviction that the proper screening of the mentally unfit at induction or recruitment was the basic solution for eliminating the psychiatric problems of military service. This is illustrated by a notation in the Annual Report of The Surgeon General of 1926 which stated that a board of officers was appointed at Fort Leavenworth, Kans., to study recruiting problems of enlisted persons who shortly thereafter were found to be mentally deficient or suffering from some form of psychosis which caused their discharge and that "studies are now underway and it is hoped that in the near future some system may be put into operation which will materially reduce the number of mentally unfit recruits who are accepted for enlistment." [22] Only occasionally was there a comment in The Surgeon General's annual reports recognizing that mental illness might be difficult to detect at the time of recruit examination. Apparently, the ease of identification of mental disorders, sufficiently symptomatic as to require hospitalization, created widespread belief that such individuals could be readily recognized at recruitment even though at a different time and under other circumstances.

It was not until 3 June 1931 that AR (Army Regulations) 600–750, "Personnel: Recruiting for the Regular Army," was revised. Paragraphs 16 and 17 of this regulation are recorded here because they pointedly exhibit one drastic effort made to compel recruiting officers to exercise

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[20] Annual Report of The Surgeon General, 1924, p. 10.

[21] *Ibid.*, p. 313.

[22] Annual Report of The Surgeon General, 1926, p. 209.

better caution in accepting applicants for enlistment. This regulation remained in force until superseded on 10 April 1939.

(Par.) 16. Improper acceptance—proceedings of board.—a. Upon arrival at a place designated for enlistment of an accepted applicant he will be examined with the least practicable delay, with a view to enlistment or rejection. b. If in the opinion of the commanding officer of the post, camp, or station the disqualification of any rejected applicant be of such a character that it should have been discovered by the recruiting officer who accepted and forwarded the applicant to the place of enlistment, the commanding officer will convene a board of three officers, one of whom will be a medical officer, to examine into the case and report whether the disqualification should have been discovered by the recruiting officer. * * *

(Par.) 17. Stoppage of pay for improper acceptance or enlistment.—Recruiting officers will be held to a strict accountability for accepting and forwarding men who may be found unfitted for the service, and officers who enlist such applicants will be held to a like accountability. If a man after having been enlisted at a military post or accepted at a recruiting station and forwarded to the designated place for enlistment be discharged or rejected, and it appears that the enlistment or acceptance was carelessly made or in violation of these regulations, the expenses incurred in consequence of the enlistment or acceptance of the man may be stopped against the pay of the officer responsible.

Psychiatric Practice

The practice of military psychiatry at large Army hospitals during this decade was similar to the diagnostic and treatment procedures in comparable civilian institutions. Letterman General Hospital noted, in 1922, that "practically all neuropsychiatric cases in this hospital were under the direct charge of medical officers who had had special training in this line of work. * * * the importance of the neuropsychiatric conditions and their definite relation to other medical and surgical conditions is rapidly becoming more appreciated. Many requests for consultations were received." [23] William Beaumont General Hospital reported the successful treatment of psychoneurotic disorders with hysterical manifestations noting that "some of these cases after years of invalidism have been cured through the efficient handling of a skillful psychiatrist." [24]

A good deal of emphasis was placed upon the use of hydrotherapy, also recreational therapy and physiotherapy in selected cases. Thus, in 1923, Letterman General Hospital reported:

One of the most desirable features of ward No. 19 is the complete hydrotherapy plant in the basement of this building. During the past year the availability of qualified enlisted men to take charge of this work has made this department a decided success. Hydrotherapy administered in a scientific manner has been made use of day and night during the entire year with most satisfactory results.[25]

In 1927, Walter Reed General Hospital reported that its physical

[23] Annual Report of The Surgeon General, 1923, p. 226.

[24] Annual Report of The Surgeon General, 1927, p. 396.

[25] Annual Report of The Surgeon General, 1924, p. 314.

facilities were improved with four closed wards, two open wards, and one neurological ward. Malarial treatment for cerebrospinal syphilis and general paresis was used in 19 cases. The use of restraints, both chemical and mechanical, was reduced to a minimum.[26] In 1930, Walter Reed General Hospital had no facilities for the treatment of insane women. However, the neuropsychiatric staff reported favorably on the continuation of therapeutic malarial treatment and the use of pneumoencephalography for diagnosis, noting its curative effects on "obscure epileptics." [27]

During the years, there were the usual complaints of insufficient personnel, both officer and enlisted, to handle the heavy workload in psychiatry and neurology.

Aviation Psychiatry

In 1921, the School of Aviation Medicine was established at Mitchel Field, N.Y. It later moved to San Antonio, Tex. (Randolph Air Force Base). At the inception of the school, a department of neuropsychiatry was established which was concerned with the problems of psychiatry in aviation medicine, particularly personality study with a view toward selection of suitable candidates for pilot training. Instruction was given which included clinical psychiatry and paid special attention toward performing an adequate psychiatric examination for flying candidates.[28] In 1928, the Department of Neuropsychiatry of the School of Aviation Medicine announced a research program focused upon securing better methods of performing the neuropsychiatric portion of the flying examination and the evaluation of flying proficiency. "There is no subject more baffling than that of personality, and that happy combination of qualities which enter into the personality make-up of the successful flyer remains undiscovered." [29]

Instruction in psychiatry at the Army Medical School, Washington, D.C., as before World War I, consisted of a series of lectures which placed emphasis on recognition and elimination of the mentally unstable applicant for the military service and on techniques of diagnosing mental cases occurring among military personnel.[30]

PSYCHIATRY, 1930–40

Incidence of Mental Disorders

In the decade before World War II (1930–39), social and economic changes, in addition to the growing threat of war, markedly influenced

[26] Annual Report of The Surgeon General, 1927, p. 330.
[27] Annual Report of The Surgeon General, 1930, p. 336.
[28] Annual Report of The Surgeon General, 1924, pp. 264–269.
[29] Annual Report of The Surgeon General, 1928, p. 325.
[30] *Ibid.*, p. 317.

both the frequency and the nature of military psychiatric problems. Beginning in 1930, traumatic injury from automobile accidents replaced suicide as the leading cause of death in Army personnel. This change took place despite increased suicide rates during this period. The lowest suicide rate of the Army after 1900 occurred during World War I with a frequency of less than 0.2 per 1,000 enlisted strength. After 1918, there was a steady upward trend which reached a peak of over 0.5 per 1,000 strength in the severe depression years (1931–34) but never attaining the high rate of suicide before World War I (over 0.6 per 1,000 strength per year). From 1935, the suicide rate declined, and in 1939, the rate of 0.29 per 1,000 strength was the lowest suicide record of the previous 10 years.[31]

For reasons not explainable, admissions for alcoholism, acute, chronic, and with psychosis, except for 1 year (1931) decreased steadily in an irregular fashion from 7.2 per 1,000 strength in 1930 to 3.3 in 1939. This decline was even accelerated after the repeal of prohibition in 1933.[32] It is probable that several factors were involved in the reduction of alcohol admissions, including an improved quality of enlistees; policy changes which discouraged the hospitalization of uncomplicated acute alcoholism, a major source of alcohol admissions; and greater psychiatric sophistication than hithertofore which fostered diagnoses of personality, neurotic, or psychotic disorders for many individuals whose alcohol excesses were found to be a manifestation of mental abnormality or disease.

Incidence Rates Versus Quality and Quantity of New Accessions

Admissions for mental disorders were also fewer than those of the previous decade, ranging from 7 to 9 per 1,000 strength in 1930–39, as compared to 11 to 12 per 1,000 strength in 1920–29. In part, at least, a cause for this decline was the widespread economic depression which made available more qualified recruits than in previous years. It is pertinent to note that decreased psychiatric admissions began in 1931 rather than at the beginning of the depression. Indeed, The Surgeon General reported that notwithstanding the large amount of unemployment there was little improvement in the character of recruits during the year 1930.[33] However, an improvement was noted in 1931 when it was reported that because of the increase in the number and quality of the applicants "the recruiting service has among other things insisted upon a higher mental standard, the score of the intelligence test having been raised to a minimum of 50 from 44."[34]

Another concurrent circumstance during this period which contributed to the decreased frequency of psychiatric admissions involved a lessened

[31] Annual Reports of The Surgeon General, 1931, pp. 44—46; 1940, pp. 66—68.

[32] Annual Report of The Surgeon General, 1940, pp. 51–52.

[33] Annual Report of The Surgeon General, 1931, pp. 3, 63, 406.

[34] Annual Report of The Surgeon General, 1932, p. 307.

input of personnel new to military service. It has been a common observation that discharges for medical reasons mainly occur from men in their first enlistment. This is particularly true for nervous and mental disorders. Thus, in 1931, The Surgeon General reported: "In 52 percent of the men who were discharged for disease of the nervous system, the condition became apparent during the first year of service, in an additional 15 percent during the second year, and in 7 percent during the third year, a total of 74 percent during the first term of enlistment." [35] These findings indicate that a decreased proportion of recruits in the troop population could favorably influence the incidence of mental disorders. Such circumstances prevailed in 1931, 1932, and 1933, when new enlistments comprised 10 to 14 percent of the total enlisted strength. During this period, psychiatric admissions declined to 7.4 percent in 1933, the lowest rate of the post-World War I era.[36] However, as stated previously, also operative during this period was the depression which produced an availability of well-qualified recruits. It is therefore reasonable to conclude that two conditions will contribute toward reducing the rate of psychiatric admissions: (1) Well-qualified recruits from the standpoint of intelligence or educational level, and (2) a stabilized military force with only a small number of accessions each year.

From 1934 to 1939, the increasing size of the Army and a corresponding rise in the percentage of new enlistments, along with a gradual lessening of the economic depression, reversed the favorable conditions of the previous several years. The psychiatric admission rate rose to 8.5–9 per 1,000 strength per annum.[37] The lesson that can be learned from the aforestated data indicates that in any mobilization period, with its large numbers of new inductees, a significant elevation of the incidence of psychiatric disorders should be expected.

Renewed Emphasis on Psychiatric Screening

Despite the foregoing evidence of the importance of personnel input in determining the incidence of psychiatric disorders, there continued to be in this decade as well as the previous 10 years a constant reiteration relative to the need for more effective psychiatric screening of recruits. In 1931, it was again stated:

> Mental and nervous diseases are of increasing importance as a cause of military unfitness. Since the World War they have caused 44 percent of all discharges for physical or mental unfitness among the white enlisted men serving in the United States, which is more than three times as great as prior to the Spanish-American War, and more than twice as great as between that war and the beginning of the World War. This should not, however, be considered as evidence of the increasing prevalence of

[35] Annual Report of The Surgeon General, 1931, p. 5.

[36] Annual Reports of The Surgeon General, 1932–34.

[37] Annual Reports of The Surgeon General, 1935–38, 1940.

such conditions in our population, but rather chiefly as an indication of the unsatisfactory results of our present system of the physical examination of applicants for enlistment, and to a lesser extent to refinements in diagnosis.[38]

Various corps and department surgeons repeated this criticism of unsatisfactory recruit examination and argued against assignment to the recruiting of any available medical officer, usually retired, and often a civilian physician. They recommended placing recruits on a probationary period and then for a board of especially qualified and trained medical officers to pass on their eligibility. Enlistment would be completed only when the probationer had been demonstrated to be free from disqualifying defects. It was further suggested that only Regular Army medical officers perform the examinations of applicants rather than civilian doctors unaccustomed to Army requirements.[39] The School of Aviation Medicine also maintained considerable interest in the area of selection. Research efforts were continued toward the development of objective tests to be used in connection with personality studies in selecting candidates for flying.[40]

With the foregoing preoccupation with elimination of psychiatric problems at the induction level, there were occasional references that situational stress could produce emotional disability. Thus, a medical board after a 4-year study found that, after 2 years of service in the Philippine Islands, the mental and physical efficiency of officer personnel was impaired. It was recommended that a tour of service prolonged beyond 2 years be considered inadvisable.[41]

Psychiatric Practice

The practice of Army psychiatry was similar to that of the previous decade, but in the early years of the depression there was a good deal of comment relative to the shortages of personnel. The Veterans' Administration in the latter part of 1932 began to withdraw patients from Army hospitals.[42] In 1933, veteran patients of all types had been curtailed from 2,000 to 457. Also, in 1933, the Civilian Conservation Corps was established which produced a demand upon Army hospitals for their care and treatment.[43]

On 1 July and 30 December 1930, Walter Reed General Hospital placed into operation new buildings for the open- and closed-ward treatment of psychiatric patients with a capacity of over 200 beds. With pride and approval, various built-in safety features were described, such as baths set in the wall, toilets of one piece flushed by a button insert, and showers which utilized cone-shaped projections from the wall precluding the possi-

[38] Annual Report of The Surgeon General, 1931, pp. 4–5.
[39] *Ibid.*, p. 402.
[40] *Ibid.*, p. 359.
[41] *Ibid.*, p. 274.
[42] Annual Report of The Surgeon General, 1933, pp. 3, 151–152.
[43] Annual Report of The Surgeon General, 1934, pp. 139, 141.

bility of a patient's suspending himself from them.[44] This improved facility permitted a greater number of patients to be treated, and it was noted in the following year that the neuropsychiatric building was highly satisfactory. The use of malaria in the treatment of general paresis and central nervous system syphilis was continued and also implemented in selected cases of dementia praecox but "the experience was too small to warrant any opinion as to its value." [45]

Letterman General Hospital reported that if personnel were available the full time of one medical officer could be taken up with consultations alone, since such were frequently asked for, not only by medical officers but also by the local office of the Veterans' Administration. Most Army psychiatric hospitals regretted that there were inadequate facilities for the hospitalization of insane officers, or for tuberculous patients who were mentally disturbed.[46]

In general, during this period, diseases of the nervous system continued to be first as a cause of discharge with dementia praecox being the leading single cause for medical disability, eighth as a cause of admissions, fifth as a cause of time lost, and remained first in medical evacuation from oversea stations. In 1938, the category "mental alienation" was discarded in favor of the general terminology "mental disease and deficiency." Schizophrenia was adopted officially for the first time in place of dementia praecox.[47]

MOBILIZATION PERIOD

As the threat of war in Europe grew and finally became a reality in 1939, the leisurely pace of Army expansion, which began in 1935, quickened into the heightened activity of mobilization. Although our primary concern here is in military psychiatry, it is pertinent to note that medical mobilization planning was far from efficient. During the prewar period, medical planning was formulated apparently without even consulting The Surgeon General. For example, the 1938 Protective Mobilization Plan prescribed that maximum use be made of Army hospitals under the control of corps area commanders and further directed the corps area commanders to make surveys of the normal average number of vacant beds in Veterans' Administration facilities, U.S. Public Health Service hospitals, and Indian Medical Service hospitals, whose location was such as to make their use feasible for the hospitalization of Army personnel. These provisions were not well considered for the following reasons:

1. The parceling out of Army patients in driblets to fill the empty

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[44] Annual Report of The Surgeon General, 1931, p. 364.

[45] Annual Report of The Surgeon General, 1932, p. 263.

[46] *Ibid.*, pp. 270, 288.

[47] Annual Reports of The Surgeon General, 1938, p. 56; 1939, pp. 57, 109, 135.

beds of hospitals not under military control was administratively unsound and insufficient to meet the expected needs of mobilization.

2. The data which the corps area commanders were directed to secure by surveys were readily available at the respective headquarters of the Veterans' Administration, the U.S. Public Health Service, and the Bureau of Indian Affairs, in Washington, D.C.

3. The Protective Mobilization Plan had completely forgotten one of the most successful and notable lessons of World War I: the formation of military hospitals by civilian medical institutions (hospitals and medical schools).[48]

It was well after the publication of the 1938 Protective Mobilization Plan that, in March 1939, The Surgeon General reminded the War Department General Staff of the outstanding success of the volunteer hospitals in World War I and requested approval for the sponsored system of general, evacuation, surgical, and station hospitals. On 3 August 1939, the Secretary of War approved the organization of affiliated reserve units as recommended by The Surgeon General.[49]

Psychiatric Planning for War

In contrast to the endeavors of The Surgeon General in planning for the medical and surgical problems of mobilization, there was no comparable effort in the sphere of military psychiatry. Such an omission is all the more surprising because the experience of even the peacetime Army after World War I had demonstrated the prevalence of psychiatric disorders of such magnitude as to be the subject of repeated comment in the Annual Reports of The Surgeon General since 1920. Moreover, as indicated previously in this chapter, there was clear evidence that the induction of large numbers of newly mobilized personnel would significantly increase the incidence of psychiatric disorders. Further and most important, there was the documented history of World War I, as well as accounts from other previous wars, which provided abundant evidence that combat would produce large numbers of psychiatric casualties. Indeed, World War I experience indicated that for every four men wounded there would be one psychiatric battle casualty.[50]

Despite the foregoing data that were available to responsible authorities, there was no effective plan or real preparation for the utilization of psychiatry by the Army in World War II. The Army had no criteria or procedure for the induction of a large fighting force. Facilities for the care and treatment of psychiatric cases were only barely sufficient for the small peacetime Army. Even the value of the division psychiatrist which

[48] Kreidberg, Marvin A., and Henry, Merton G.: History of Military Mobilization in the U.S. Army, 1775–1945. Washington: U.S. Government Printing Office, 1955. (DA Pamphlet 20–212.)

[49] Annual Reports of The Surgeon General, 1939, p. 179; 1940, p. 177.

[50] Menninger, *op. cit.*, p. 11.

had been so clearly demonstrated in World War I was forgotten. With the reorganization of combat divisions in 1941, in a move toward economy of personnel, the psychiatrist was dropped from the divisional medical staff, which deletion was apparently agreed to by medical officers in charge of plans and training in the Surgeon General's Office at that time. According to Overholser,[51] the civilian psychiatrists who were endeavoring to offer help in Army planning were apparently unaware of the fact that division psychiatrists were omitted from War Department Table of Organization No. 8–21, 1 November 1940. It was not until November 1943 that they were reinstated.[52]

Career Military Psychiatrists

From the standpoint of career military personnel, there were relatively few trained psychiatrists in the Regular Army. Although the Army (and the Navy) had been sending medical officers to St. Elizabeths Hospital for psychiatric training since 1909, there were only a scant number during this period (fewer than 20) on active duty status who had received psychiatric training.[53] In 1940, although there were 35 medical officers of the Regular Army Medical Corps assigned to psychiatric positions, "only four were certified by the American Board of Psychiatry and Neurology, and many of the others had had no formal specialized psychiatric training." [54] In addition, psychiatry occupied a subordinate role, functioning as a section under the medical service in Army hospitals and having little influence in policy decisions at the level of the Surgeon General's Office.

During the expansion of mobilization and at the onset of hostilities, the vast majority of Regular Army psychiatrists, like other career medical officers, were transferred to command and administrative assignments. Only Col. William C. Porter, MC, remained throughout the wartime period in a purely professional psychiatric position. Col. Ernest H. Parsons, MC, commanded an oversea psychiatric hospital, and Col. Cleve C. Odom, MC, succeeded to the command of two Army general hospitals (Darnall and Mason General Hospitals) which were exclusively devoted to the care and treatment of neuropsychiatric patients. Thus, the practice of psychiatry in the Army during World War II became the responsibility of newly inducted physicians with little or no military experience. In brief, as in World War I, Army psychiatry in World War II was fated to be primarily a civilian psychiatric effort. For this reason, it is appropriate to consider

[51] Overholser, Winfred: Early Steps in Psychiatric Mobilization. [Unpublished manuscript.]

[52] War Department Circular No. 290, 9 Nov. 1943, recreated and authorized the position of division psychiatrist and outlined his duties.

[53] Brig. Gen. Eugen G. Reinartz, Col. Walter A. Carlson, Col. Rawley E. Chambers, Col. (later Brig. Gen.) Sidney L. Chappell, Col. Frank H. Dixon, Col. Walter S. Jensen, Col. Edward J. Kendricks, Col. John M. Caldwell, Col. Harry E. Hearn, Lt. Col. George E. Hesner, Col. Francis E. Weatherby, Col. Emmett B. Litteral, Col. Patrick S. Madigan, Col. Cleve C. Odom, Col. Ernest H. Parsons, Col. William C. Porter, and Brig. Gen. William L. Sheep.

[54] Menninger, *op. cit.*, p. 14.

the state of readiness, preparation, and participation of civilian psychiatry during the mobilization period before World War II.

MOBILIZATION OF CIVILIAN PSYCHIATRY

When it became increasingly clear that the United States might be drawn into the war, individual psychiatrists and psychiatric organizations became concerned with the role of psychiatry in mobilization and made preparations to advise the military services in their special sphere. In June 1939, Dr. William C. Sandy, president of the American Psychiatric Association, appointed a committee on military mobilization "to be devoted to preparation for emergencies and to confer with other Services as to needs and as to available personnel." [55] The committee was headed by Dr. Harry A. Steckel who had served as a division psychiatrist in World War I and included Drs. Francis H. Sleeper, Appleton H. Pierce, Walter J. Otis, and Samuel W. Hamilton. Committee members met with representatives of the Surgeons General of the Army and Navy on 16 October 1939, and as a result surveyed civilian psychiatric personnel by questionnaire and prepared a list of available psychiatrists. The committee also conducted a roundtable discussion on military psychiatry at the annual meeting of the association in May 1940, made an inspection trip of the Canadian Army, and participated in conferences with selective service officials. These efforts of the American Psychiatric Association were considered mediocre by some contemporary observers. Menninger [56] stated that the committee members "worked hard but met with lukewarm interest on the part of Army authorities." More critical was Deutsch, who wrote: "It must be said, in truth, that the steps taken by the Association to give leadership and direction to the psychiatric aspects of military mobilization were at first marked by hesitation and uncertainty of purpose. * * * the American Psychiatric Association seemed content to offer its services to the appropriate authorities and patiently wait to be called." [57]

At the May 1942 meeting of the American Psychiatric Association, it was the opinion of the association that the Army and Navy were not utilizing psychiatric facilities and personnel effectively and that these resources were being "shockingly unappreciated in spite of the lesson learned from the last World War." A resolution was passed authorizing the appointment of "a well chosen committee with power to act in making forceful representation of this status of affairs." Drs. Arthur H. Ruggles, Edward A. Strecker, and Frederick W. Parsons, who composed the committee, later were appointed as consultants to The Surgeon General.[58]

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[55] Overholser, *op. cit.*

[56] Menninger, *op. cit.*, p. 10.

[57] Deutsch, A.: Military Psychiatry, World War II. *In* One Hundred Years of American Psychiatry. Published for the American Psychiatric Assoc., by Columbia Univ. Press, New York, 1944, p. 420.

[58] Overholser, *op. cit.*, p. 10.

However, Menninger stated that "not until 1944 did the Neuropsychiatry Consultants Division of the Surgeon General's Office request consultation with these men regularly." [59]

One of the first groups advocating psychiatric mobilization was the William Alanson White Psychiatric Foundation of Washington, D.C. In October 1939, a committee of the foundation was constituted to aid in "the more effective utilization of psychiatry in the national defense." [60] Through the efforts of its president, Dr. Harry Stack Sullivan, the foundation, by the publication of articles and speeches, vigorously urged greater psychiatric participation in planning for mobilization. Particularly emphasized was the need for adequate psychiatric screening of draft registrants.

Another important influence for psychiatric screening was the Federal Board of Hospitalization which, on 16 July 1940, adopted a resolution regarding additional hospital beds which might be required in a national emergency. One provision of the resolution stated: "The Board also finds that clearly associated with this problem is the careful physical examination of men upon entry into military service in order to eliminate as far as possible later potential claims against the Government arising out of disabilities existing at the time of induction into service." The resolution was given weight in the psychiatric sphere by an extensive memorandum requested by the Board from Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, also a member of the Board, which, while dealing with the additional hospital beds that would be required for men discharged from the Armed Forces for nervous and mental disease, placed particular emphasis upon the need for thorough psychiatric screening of inductees prior to entry into the service. Both the resolution and the memorandum by Dr. Overholser were favorably received by President Roosevelt on 17 September 1940 and transmitted to Mr. Frederick H. Osborn, Chairman of the National Advisory Committee on Selective Service, who, impressed by the importance of psychiatric screening, forwarded the recommendations to the Medical Division of the National Headquarters of the Selective Service.[61]

Psychiatry and Selective Service

As a result of the foregoing events, on 24 October 1940, the Director of Selective Service, Dr. Clarence A. Dykstra, representatives from various divisions of the War Department, and Drs. Overholser, Steckel, and Sullivan conferred and made plans for placing a psychiatrist in each of the 660 medical advisory boards. Medical advisory boards in the selective service organization were composed of civilian specialists in the various fields of medicine on whom the medical examiner of the local draft board could call

[59] Menninger, *op. cit.*, p. 10.
[60] Deutsch, *op. cit.*, p. 421.
[61] Overholser, *op. cit.*

for assistance in questionable cases. Thus, when the draft began in November 1940, the process of induction included psychiatric assistance, if needed, as part of the physical examination.[62]

At this time, medical examination of draft registrants consisted of a double screening process. Medical examiners of local draft boards rejected individuals with obvious defects. Doubtful cases were referred to the medical advisory board. Successful registrants from this initial phase were sent to the Army induction station for the final physical and psychiatric examination.[63]

To implement the psychiatric aspects of the induction program, Dr. Harry Stack Sullivan was appointed as psychiatric consultant to Selective Service. In October 1940, a committee of the William Alanson White Psychiatric Foundation had prepared a plan for the psychiatric examination of draft registrants. Through the influence of Dr. Sullivan, this plan became the basis for the Selective Service System's Medical Circular No. 1, issued on 7 November 1940. The purpose of the circular, entitled "Minimum Psychiatric Inspection," was to aid the medical examiners of the 6,403 local draft boards in detecting disabling mental and personality disorders of draftees.[64] In addition, Dr. Sullivan, with the aid of prominent civilian and military psychiatrists, conducted 2-day seminars in nine major cities, during the period from January to July 1941, to assist psychiatrists serving with medical advisory boards and Army induction stations.[65] On 12 March 1941, The Surgeon General issued Circular Letter No. 19, to supplement and amplify the Selective Service System's Medical Circular No. 1. This circular was designed to supply medical examiners at Army induction stations with the same type of psychiatric orientation as had been given the medical examiners of local draft boards.[66]

As time and events proceeded, complications soon arose with the psychiatric portion of the induction process, particularly as the tempo of military mobilization increased. Col. Leonard G. Rowntree, MC, who had been appointed medical director of Selective Service in 1941, and Maj. Gen. (later Lt. Gen.) Lewis B. Hershey, who had succeeded Dr. Dykstra as Selective Service Director, were "somewhat discouraged to learn that despite this psychiatric screening, considerable numbers of men were subsequently being discharged from the Army because of mental derangement." [67] Also, after Pearl Harbor, the rapid acceleration of the draft process, to supply the needs of the vastly expanded Army, forced abandonment in January 1942 of the preliminary local draft board examination in favor of a single screening examination procedure at Army induction centers under Army supervision. This change was opposed by Dr. Sulli-

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[62] Menninger, *op. cit.*, p. 268.
[63] Deutsch, *op. cit.*, p. 422.
[64] *Ibid.*
[65] Menninger, *op. cit.*, p. 269.
[66] Deutsch, *op. cit.*, p. 422.
[67] Menninger, *op. cit.*, p. 269.

van, and many other psychiatrists, and was protested editorially in the *American Journal of Psychiatry*.[68] Other differences of opinion between Dr. Sullivan and General Hershey developed which led eventually to the resignation of Dr. Sullivan as psychiatric consultant. Dr. Raymond W. Waggoner was appointed psychiatric consultant to the Selective Service in the fall of 1943.

National Research Council

Another organization concerned with psychiatric mobilization was the National Research Council. In October 1940, a committee on neuropsychiatry of the National Research Council was constituted to aid the Surgeons General in neuropsychiatric problems pertaining to national defense. This committee was headed by Dr. Overholser and included Drs. Franklin G. Ebaugh, Foster Kennedy, Adolf Meyer, Tracy J. Putnam, Harry A. Steckel, and John C. Whitehorn.

Through appropriate subcommittees on personnel and training, neurology, psychiatry, and neuroses, the National Research Council endeavored to advise the Surgeons General on military problems of neurology and psychiatry. The Subcommittee on Personnel listed and rated all available civilian psychiatrists and neurologists which was stated by Dr. Overholser to have been found useful by The Surgeon General. Another early task was the revision of the Army's standards of physical examination during mobilization, better known as MR (Mobilization Regulations) 1–9. Many recommendations were not followed, or were only acted upon after a considerable period of time had elapsed. Thus, in June 1941, the committee recommended that a Division of Psychiatry be set up in the Surgeon General's Office and a psychiatric consultant be assigned to each corps area. This proposal was declined by the Army "as not being in accordance with the present policy." Also, in June 1941, the committee recommended that clinical psychologists be taken into the Medical Department to work with psychiatrists, but a military liaison with clinical psychology was not effected until much later. In February 1941, the committee recommended that inductees be held as long as 5 days at induction stations for observation, if necessary. However, such a procedure was never really implemented. In 1942, the committee recommended setting up civilian training courses for psychiatry, but the Surgeon General's Office did not see the desirability at that time, although in 1944 such training was accomplished.[69]

Conclusions

In looking back over the efforts of civilian psychiatry during the mobilization and early phases of World War II, it can be fairly stated that

[68] Overholser, *op. cit.*
[69] *Ibid.*

its accomplishments were modest when compared to the more effective work of the National Committee for Mental Hygiene in World War I. There are several circumstances that could account for the difference in the psychiatric participation of the two wars. During the era before World War II, there was little or no enthusiasm for war in contrast to the excitement and high morale of World War I. The lack of martial songs in World War II was evidence of the general pessimistic attitude of the population.[70] It is also highly likely that Dr. Salmon's group was better received by Army authorities in World War I than their counterparts in World War II. In this writer's opinion, another reason lay in the major premise of both civil and military psychiatry groups which placed disproportionate emphasis upon screening at induction as the solution to the psychiatric problem. Forgotten was the fact that Dr. Salmon and his group prepared plans and argued for both selection and treatment; were concerned with the construction of psychiatric treatment facilities and the procurement of psychiatric personnel, including nurses and ward attendants; insisted upon the staffing of combat divisions with psychiatrists; and provided for special psychiatric hospitals in the combat zone. It was inevitable that, after World War II, Brig. Gen. William C. Menninger, Chief Psychiatric Consultant in the U.S. Army, wrote:

> We expected too much from induction center screening and fell in with the overselling of what psychiatry could accomplish at this level * * *.
>
> Initially we were blind to the needs and ignorant of the methods of preventive psychiatry.[71]

It may be concluded that an important lesson to be learned from the trials and experiences of psychiatric mobilization in World War II is the error in placing emphasis upon psychiatric screening to the exclusion of prevention and treatment. In war, psychiatric casualties will surely occur as new personnel enter military service and encounter the stress of training, oversea service, and combat. A study of these problems will inevitably lead to possibilities for early treatment and prevention. As Mira has stated from his experiences in the Spanish Civil War "to prevent or detect early exhaustion in an overworked commander is much more important than to make a fair classification of one hundred inductees." [72]

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[70] Menninger, *op. cit.*, p. 88

[71] *Ibid.*, p. 41.

[72] Mira, Emilio: Psychiatry in War. New York: W. W. Norton & Co., 1943.

Part II

ADMINISTRATIVE CONSIDERATIONS IN THE SURGEON GENERAL'S OFFICE

CHAPTER II

Status and Development

Malcolm J. Farrell, M.D.

EARLY ORGANIZATION

On 19 July 1917, The Surgeon General authorized the establishment of a Neurology and Psychiatry Division as a part of the Surgeon General's Office.[1] This division functioned throughout World War I under the direction of Col. Pearce Bailey, MC, formerly of the Neurological Institute, New York, N.Y. With the cessation of hostilities, the division became a section on 30 November 1918, under the chief consultant in medicine.[2] Between World Wars I and II, no psychiatrist served in the Surgeon General's Office until a neuropsychiatrist, Lt. Col. (later Col.) Patrick S. Madigan, MC, a Regular Army medical officer, was assigned to the Professional Service Division on 1 August 1940. His chief functions, however, were to review Army retiring board proceedings, reports of line-of-duty findings of accidents and injuries, and correspondence regarding psychiatric matters.

In February 1942, Maj. Gen. James C. Magee, The Surgeon General, following the example of the previous wartime Surgeon General,[3] established a separate Neuropsychiatry Branch. Colonel Madigan was appointed chief of the new branch. This branch, however, unlike the independent division of World War I, was one of several branches under the Professional Service Division.

Within a short time, the degree and complexity of functions made it apparent that the branch would require expansion. Without an adequate staff, it was impossible to visit the various field installations and investigate psychiatric problems at firsthand. Accordingly, Maj. (later Lt. Col.) Malcolm J. Farrell, MC (fig. 1),[4] was assigned, on 10 April 1942, to assist Colonel Madigan.

Despite the lessons learned in World War I and recorded in the history of that war, no plans were made for meeting the problems of World War II. Therefore, much of the time of the newly organized branch was spent in attempting to solve problems which, in many instances, were repetitions of those of the last war.

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[1] War Department Special Orders No. 166, 19 July 1917, par. 137.

[2] Office Order No. 97, Surgeon General's Office, 30 Nov. 1918.

[3] Maj. Gen. William C. Gorgas, The Surgeon General, 16 Jan. 1914–3 Oct. 1918.

[4] Formerly Assistant Superintendent, Walter E. Fernald State School, Waverly, Mass., and instructor of psychiatry, Boston University Medical School, Boston, Mass.

FIGURE 1.—Lt. Col. Malcolm J. Farrell, MC, Assistant Director, Neuropsychiatry Consultants Division, Surgeon General's Office, 10 April 1942–15 June 1945.

The Neuropsychiatry Branch was severely handicapped by lack of personnel, information, and statistics. In the last-named case, there was one period when the wartime statistics were retarded almost 2 years. Only after a complete reorganization of the Statistical Division, SGO (Surgeon General's Office), could the Neuropsychiatry Consultants Division obtain reliable statistical data upon which to base a true estimate of the neuropsychiatric situation.

Because Colonel Madigan was to be transferred to the Adjutant General's Office, The Surgeon General sought a replacement. He had been made aware of the need of support from civilian psychiatric groups and thus requested Dr. Winfred Overholser, secretary of the American Psychiatric Association, to submit a list of possible replacements. The list was to include outstanding, well-known, and mature psychiatrists who would have ability, recognition, and civilian support to assume the duties of the chief of the branch and, therefore, those of the chief consultant in neuropsychiatry for the Army. After due deliberation, Dr. Roy D.

Halloran[5] was selected. Colonel Madigan was transferred on 15 August 1942, and Dr. Halloran reported for duty on 17 August 1942 in the rank of colonel (fig. 2).

FIGURE 2.—Col. Roy D. Halloran, MC, Director, Neuropsychiatry Division, Surgeon General's Office, 17 August 1942–10 November 1943.

CHANGING CONCEPTS

During early mobilization in 1940, the consensus of prominent civilian and military psychiatrists was that a major effort should be made to eliminate potential psychiatric casualties by screening at the induction level. It was believed that this procedure would eliminate or at least mitigate serious psychiatric problems, if any, during the war. As a result, the main function of psychiatrists in the Army would be to detect and screen out the men who had escaped detection at the induction station. As the war progressed, it was discovered that this reliance upon selection and elimination failed to prevent the appearance of large numbers of psychiatric cases. It also soon became apparent that neuropsychiatric difficulties

[5] Formerly Superintendent, Metropolitan State Hospital, Waltham, Mass., and professor of clinical psychiatry, Tufts College Medical School, Boston, Mass.

had become one of the most serious medical and manpower problems facing the Medical Department and the Nation. It was obvious, therefore, that considerable planning and action would be necessary to prevent this ever-increasing loss of manpower. As a step in this direction, The Surgeon General approved the addition to the Neuropsychiatry Branch of an officer whose main interest would be to carry out a preventive program. On 24 March 1943, 1st Lt. (later Maj.) John W. Appel, MC,[6] was appointed to the branch. Since it was believed that the morale of soldiers was intimately related to the causes of mental disorders in the Army, close liaison between the Neuropsychiatry Branch and the Special Services Division,[7] ASF (Army Service Forces), was considered desirable. Lieutenant Appel was appointed liaison officer with this division (p. 120).

FIGURE 3.—Lt. Col. Walter E. Barton, MC, Chief, Occupational Therapy Branch, Neuropsychiatry Division, Surgeon General's Office, 22 April 1943–19 August 1943.

[6] Formerly psychiatrist on the staff of the Institute of the Pennsylvania Hospital, and instructor in psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.

[7] Later known as the Morale Services Division and, subsequently, as the Information and Education Division.

Necessity of Treatment

Even before Pearl Harbor, and certainly soon thereafter, the increasing numbers of psychiatric inpatients made evident the need for a treatment program. Early in the war, the Army policy was to discharge psychiatric patients as soon as possible after an adequate diagnosis had been made. Even then, it was necessary to provide treatment for patients awaiting discharge. To aid in furthering the psychotherapeutic and somatic treatment program, Maj. (later Lt. Col.) Walter E. Barton, MC (fig. 3),[8] was assigned to the Neuropsychiatry Branch on 22 April 1943. He immediately began to plan for occupational therapy facilities in Army hospitals. Major Barton remained assigned to this branch until the establishment of the Reconditioning Division, which absorbed the occupational therapy functions. Major Barton was then transferred to that division on 19 August 1943. Later in the war, a more definitive type of treatment, rather than mere inpatient activity, became necessary. This definitive treatment became the problem of the Psychiatry Section of the Neuropsychiatry Branch.

FIGURE 4.—Lt. Col. William H. Everts, MC, Chief, Neurology Branch, Neuropsychiatry Consultants Division, Surgeon General's Office, 1 January 1944–6 July 1945.

[8] Formerly Assistant Superintendent, Worcester State Hospital, Worcester, Mass., and lecturer in social psychiatry, Smith College, Northampton, Mass.

Increased Neuropsychiatric Demands and Necessary Changes

The pressure of increasing neuropsychiatric demands became so great that the Neuropsychiatry Branch was forced to eliminate all earlier activities unrelated to psychiatry. Even with this relief, however, the four officers, then assigned, were barely able to cope with the routine activities of the branch. Among the problems showing a decided increase were those of a purely neurological nature. These required expert technical supervision and the formulation of policies at the level of the Surgeon General's Office. Accordingly, Maj. (later Lt. Col.) William H. Everts, MC (fig. 4),[9] was transferred to the branch on 3 October 1943 to perform such duties in relation to neurology.

Colonel Halloran continued as chief of the branch until his sudden

FIGURE 5.—Brig. Gen. William C. Menninger, Director, Neuropsychiatry Consultants Division, Surgeon General's Office, 10 December 1943–30 June 1946.

[9] Formerly instructor in neurology, Neurological Institute, New York, N.Y., and attending neurologist, Neurological Institute, French Hospital, New York, N.Y., New Rochelle Hospital, New Rochelle, N.Y., and Grasslands Hospital, Valhalla, N.Y.

and untimely death on 10 November 1943, which came as a severe shock to his coworkers in the branch and in the field. Colonel Farrell assumed the duties as acting chief until a successor was appointed.

On 17 December 1943, Lt. Col. (later Brig. Gen.) William C. Menninger, MC (fig. 5),[10] was appointed as chief consultant in neuropsychiatry and chief of the Neuropsychiatry Branch.

NEUROPSYCHIATRY DIVISION

On 29 November 1943, a plan was proposed to elevate the Neuropsychiatry Branch to the status of a division[11] on a level with surgery and medicine. It suggested that the Neuropsychiatry Division be divided into four branches: Psychiatry, Neurology, Preventive Psychiatry, and Clinical Psychology. The plan also detailed the functions of each of these branches.

Maj. Gen. Norman T. Kirk, The Surgeon General, along with Brig. Gen. Charles C. Hillman, Chief, Professional Service, SGO, recognized the nature and magnitude of the neuropsychiatric problem and supported the elevation of the specialty to the status of a division.[12] In the subsequent reorganization of the Professional Service, neuropsychiatry was thus recognized, and the specialty was made a representative division of the Surgeon General's Office on 1 January 1944. This change permitted the alteration and expansion of the former Neuropsychiatry Branch; it added more personnel and placed them in positions of more prestige. This permitted the new division to deal with the many tasks and problems that confronted it through more direct contact with higher echelons.

In order to cope more effectively with the increasing problems, Colonel Menninger submitted a second memorandum[13] to General Hillman in which he recommended an increase in the number of officer personnel

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[10] Consultant in Neuropsychiatry, Fourth Service Command, 25 November 1942–10 December 1943. Formerly medical director, Menninger Psychiatric Hospital, and president, board of governors, The Menninger Foundation, Topeka, Kans.

[11] Memorandum, Lt. Col. Malcolm J. Farrell, MC, Acting Chief, Neuropsychiatry Branch, for Brig. Gen Charles C. Hillman, Chief, Professional Service, SGO, 29 Nov. 1943, subject: Proposed Plan of Reorganization of a Division of Neuropsychiatry.

[12] It would be a serious deficiency in this history not to record the assistance and encouragement given to neuropsychiatry by General Kirk, The Surgeon General. In many instances, his active and personal support carried through measures which otherwise never would have materialized. The best example of this is the part he played in the winning of the final approval of the appointment of division psychiatrists. Efforts had been made constantly since September 1942 to reestablish the position of division psychiatrist. In November 1942, the European theater requested approval by the War Department. Approval was repeatedly blocked by the Operations Service of the Surgeon General's Office and the Army Ground Forces in spite of the proved usefulness of such officers in World War I. When General Kirk returned from his visit to North Africa, he was convinced of the need for these officers. One of his first acts as The Surgeon General, following his appointment on 1 June 1943, was to reopen the question. Determined opposition was encountered from Army Ground Forces, the argument presented being that the position was not necessary and that no such position could be allotted in the new streamlined triangular division. General Kirk personally appeared at the hearing called by G–1 of the War Department to listen to the arguments on both sides. General Kirk's own vigorous argument in favor of such appointments without doubt resulted in approval by the War Department in November 1943.—M. J. F.

[13] Memorandum, Lt. Col. William C. Menninger, Director, Neuropsychiatry Division, for Brig. Gen. Charles C. Hillman, Chief, Professional Service, SGO, 22 Jan. 1944, subject: Father Organization of the Neuropsychiatric Division.

from 4 to 10. He gave a brief analysis of the situation, divided the division into three branches, and detailed the function and job description of each of his assistants. The three branches were designated Psychiatry, Neurology, and Mental Hygiene.

Personnel Additions

The assignment of three additional officers was finally approved. On 7 February 1944, Capt. (later Maj.) Ivan C. Berlien, MC,[14] was transferred to the Psychiatry Branch of the new division. Major Berlien's principal duties were centered upon problems of induction, personnel, division psychiatry, and disciplinary problems. Maj. (later Lt. Col.) Norman Q. Brill, MC (fig. 6),[15] was assigned to the division on 13 March 1944 as chief of

FIGURE 6.—Lt. Col. Norman Q. Brill, MC, Chief, Psychiatry Branch, Neuropsychiatry Consultants Division, Surgeon General's Office, 13 March 1944–8 October 1945.

[14] Formerly instructor in psychiatry, Wayne State University College of Medicine, Detroit, Mich.

[15] Formerly instructor in neurology, Columbia University College of Physicians and Surgeons, New York, N.Y.

FIGURE 7.—Maj. David W. Hilger, MC, Assistant Chief, Mental Hygiene Branch, Neuropsychiatry Consultants Division, Surgeon General's Office, 29 April 1944–9 June 1945.

the Psychiatry Branch. Capt. (later Maj.) David W. Hilger, MC (fig. 7),[16] was transferred to the division on 29 April 1944 and assigned as assistant chief of the Mental Hygiene Branch.

The mental hygiene consultation services at replacement training centers had since their inception [17] been considered a very important function of the Army psychiatric program. To provide more effective supervision, coordination, and standardization of the clinics, Maj. (later Lt. Col.)

[16] Reserve medical officer called to active duty on 3 July 1941 after completion of residency at University of Minnesota; transferred from Schick General Hospital, Clinton, Iowa, where he served as chief of the neuropsychiatry section.

[17] At least three such clinics were functioning before they were officially approved and authorized in October 1942: The Signal Corps Replacement Training Center, Fort Monmouth, N.J., by Lt. Harry L. Freedman, MC; the Engineer Replacement Training Center, Fort Belvoir, Va., by Capt. Bernard A. Cruvant, MC; and the Anti-Aircraft Replacement Training Center, Camp Callan, Calif., by Capt. Julius Schreiber, MC.

FIGURE 8.—Lt. Col. Manfred S. Guttmacher, MC, Chief, Consultation Services, Neuropsychiatry Consultants Division, Surgeon General's Office, 15 September 1944–30 July 1945.

Manfred S. Guttmacher, MC (fig. 8),[18] was assigned to the division on 15 September 1944. Since the majority of psychiatric social workers in the Army were assigned to the consultation services, Major Guttmacher had the additional duty of supervising these workers.

Further Reorganization

In the further reorganization of the Surgeon General's Office, the Office of the Chief of Professional Service was abolished on 25 August 1944. The Neuropsychiatry Division was redesignated as the Neuropsychiatry Consultants Division and, as a separate division, was directly responsible to the Deputy Surgeon General and the Executive Officer. As a result, the function of the Neuropsychiatry Consultants Division became more professional, and administrative matters were handled by or directly with the chief of the Professional Administrative Service or the chief of

[18] Formerly Chief Medical Officer of the Supreme Bench of Baltimore; instructor in psychiatry, Johns Hopkins University School of Medicine.

the Operations Service.[19] At this time, the director of the division became eligible for membership on The Surgeon General's special staff. Until then, no representative of neuropsychiatry had attended meetings of that special staff.

Clinical Psychology

Clinical Psychology did not become a branch of the Neuropsychiatry Consultants Division until 1 September 1945.[20] The few commissioned psychologists in the Sanitary Corps, assigned to general hospitals, and those assigned elsewhere, all came under the jurisdiction of the Adjutant General's Department. Although clinical psychology was considered an important adjunct in the diagnosis and management of psychiatric cases, all earlier efforts to bring psychology under the supervision of The Surgeon General, and more specifically neuropsychiatry, failed until the very end of the war. Fortunately, chiefs of psychiatric services and sections in the field recruited and trained mostly enlisted personnel, with or without prior training, in some of the functions of the clinical psychologist. When the transfer of responsibility was made, commissioned psychologists also transferred to the Medical Administrative Corps. Lt. Col. Morton A. Seidenfeld, MAC,[21] Chief Clinical Psychologist, Adjutant General's Department, was transferred in that same capacity to the Surgeon General's Office and became Chief, Psychology Branch, Neuropsychiatry Consultants Division. Capt. (later Maj.) Lawrence I. O'Kelly, MAC,[22] also transferred, continued as assistant to Colonel Seidenfeld.

Psychiatric Social Workers

The need for the utilization of psychiatric social workers was made evident in the Army (p. 626), even in the early operations of Selective Service. Other contributions that they made to the neuropsychiatry program were particularly demonstrated in the function of the mental hygiene consultation services. In February 1943, the Chief of the Neuropsychiatry Branch expressed his desire to have on his staff a qualified psychiatric social worker who could supervise other workers in this specialty. It was not until 18 October 1943, however, that MOS (Military Occupational Specialty) 263 was established for this type of personnel. From that time on, the services and numbers of psychiatric social workers increased considerably. Despite almost herculean efforts, however, the Psychiatric Social Work Section was not established until 1 July 1945,

[19] It would be amiss here not to express appreciation for the active interest and support that General Hillman gave this division during his tenure as Chief of Professional Service. He was unusually well oriented psychiatrically and was keenly aware of the psychiatric problem in the Army.—M. J. F.

[20] War Department Circular No. 264, 1 Sept. 1945.

[21] Formerly Director of Rehabilitation, Chicago and Cook County Tuberculosis Institute.

[22] Formerly instructor in psychology, University of Colorado, Denver, Colo.

with Maj. Daniel E. O'Keefe, MAC,[23] on loan to this office from the Adjutant General's Office. Major O'Keefe was formally transferred to the Surgeon General's Office and became chief of the Psychiatric Social Work Branch which was established on 10 September 1945.

Later Personnel Changes

The policy of the Army Service Forces, as described in ASF Circular No. 151, 27 April 1945, resulted in a change of station for several personnel assigned to the Neuropsychiatry Consultants Division. This circular

FIGURE 9.—Maj. Alexander T. Ross, MC, Chief, Neurology Branch, Neuropsychiatry Consultants Division, Surgeon General's Office, 24 July–20 December 1945.

[23] Formerly director of social service, U.S. Public Health Service Hospital, Lexington, Ky.

required that all full-duty personnel and those on limited duty who could serve overseas and had not had the opportunity of serving there permanently be replaced by officers returning from overseas. Accordingly, Major Hilger, Assistant Chief of the Mental Hygiene Branch, was reassigned on 9 June 1945 and was replaced by Maj. Herbert S. Gaskill, MC,[24] from the China-Burma-India theater. Colonel Farrell was reassigned on 15 June 1945 and was replaced by Col. S. Alan Challman, MC,[25] who returned after more than 3 years' service as neuropsychiatric consultant for the Southwest Pacific Area. On 24 July 1945, Colonel Everts, Chief of the Neurology Branch, was replaced by Maj. Alexander T. Ross, MC (fig. 9),[26] from the 96th General Hospital in England. Major Berlien, Chief of Professional Supervision Section, was replaced on 16 July 1945 by Maj. John M. Flumerfelt, MC,[27] from the 38th General Hospital at Cairo, Egypt.

Expanding Functions

The function and scope of the Neuropsychiatry Consultants Division increased constantly and consistently from a very modest beginning, when the work consisted mainly of reviewing board proceedings, until long before the end of the war, when the division was concerned with a major source of manpower loss which confronted the Medical Department and the War Department. It dealt with a subject which was intangible and which captured a tremendous amount of public interest and concern. In order to cope with the problems, functional units operating as branches and sections were created as needed. Eventually, on 4 July 1945, the division had expanded to four branches and four sections. The Psychiatry Branch included the Professional Supervision Section, the General Psychiatry Section, the Training Center Section, and the Psychiatric Social Work Section. The other branches were: the Neurology Branch, the Mental Hygiene Branch, and the Clinical Psychology Branch. A fifth branch, the Psychiatric Social Work Branch, was elevated from a section in September 1945.

The division functioned as a closely coordinated team, with each officer responsible for a particular field activity. Each officer developed his own assignment and was responsible for planning or initiating changes in Army regulations, circulars, and technical medical bulletins relating to his specialty. He had the responsibility of keeping himself informed as to developments within the division so that, in an emergency, he would be competent

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[24] Formerly resident in psychiatry, Pennsylvania Hospital, Philadelphia, Pa.

[25] Formerly director, Child Guidance Clinic, Minneapolis, Minn., and clinical professor of psychiatry, Medical School, University of Minnesota.

[26] Formerly assistant professor of neuropsychiatry, Indiana University School of Medicine, Indianapolis, Ind.

[27] Formerly Rockefeller Fellow in Psychiatry at Pennsylvania Hospital for Mental and Nervous Diseases, and research psychiatrist, Department of Hygiene, Howard University, Washington, D. C.

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to give information about, or to carry out, a particular activity other than his own. This was made possible largely through staff meetings wherein each officer discussed developments within his own sphere.

During the period of 1942–46, the personnel assigned to the Neuropsychiatry Consultants Division, SGO, were as follows:

	Dates
Director:	
Lt. Col. (later Col.) Patrick S. Madigan	21 Feb.–15 Aug. 1942
Col. Roy D. Halloran	17 Aug. 1942–10 Nov. 1943
Lt. Col. Malcolm J. Farrell[1]	10 Nov.–12 Dec. 1943
Lt. Col. (later Brig. Gen.) William C. Menninger	Dec. 1943–26 June 1946
Assistant Director:	
Lt. Col. Malcolm J. Farrell	10 Apr. 1942–15 June 1945
Col. S. Alan Challman	8 Sept.–7 Oct. 1945
Lt. Col. Norman Q. Brill	Oct. 1945–15 Mar. 1946
Chief, Mental Hygiene Branch:	
Capt. (later Maj.) John W. Appel	1 Jan. 1944–3 June 1946
Chief, Neurology Branch:	
Maj. (later Lt. Col.) William H. Everts	1 Jan. 1944–6 July 1945
Maj. (later Lt. Col.) Alexander T. Ross	24 July–20 Dec. 1945
Chief, Psychiatry Branch:	
Maj. (later Lt. Col.) Norman Q. Brill	13 Mar. 1944–8 Oct. 1945
Maj. Herbert S. Gaskill	9 Oct.–21 8 Oct. 1945
Chief, Psychology Branch:	
Lt. Col. Morton A. Seidenfeld	7 Sept.–15 Nov. 1945
Capt. Lawrence I. O'Kelly	15 Nov. 1945–22 Feb. 1946
Chief, Psychiatric Social Work:	
Maj. (later Lt. Col.) Daniel E. O'Keefe	18 June 1945–12 Feb. 1946
Other members:	
Capt. (later Maj.) David W. Hilger	29 Apr. 1944–9 June 1945
Capt. (later Maj.) Ivan C. Berlien	7 Feb. 1944–5 Aug. 1945
Maj. (later Lt. Col.) Manfred S. Guttmacher	15 Sept. 1944–30 July 1945
Maj. John M. Flumerfelt	16 July 1945 4 Jan. 1946
Maj. Herbert S. Gaskill	2 June–8 Nov. 1945
Maj. (later Lt. Col.) Walter E. Barton	22 Apr.–19 Aug. 1943

[1] Acting.

CHAPTER III

Professional Personnel

Malcolm J. Farrell, M.D., and *Ivan C. Berlien, M.D.*

When the United States entered World War II, no professional specialty was fully prepared to participate in military medicine, but none was so ill-prepared as was psychiatry. Certainly, this was true insofar as numbers of available psychiatrists were concerned—before mobilization, there were fewer than 20 Regular Army medical officers with some training and experience in psychiatry. It was also true insofar as plans for mobilization and assignment were concerned. Although a neuropsychiatrist had been assigned to the Professional Service Division in the SGO (Surgeon General's Office) in August 1940, this officer had no responsibility for making plans and recruiting personnel for a program of psychiatric care. Indeed, it was not until August 1942, 7 months after Pearl Harbor, that a psychiatrist was assigned to serve as the chief consultant in neuropsychiatry to The Surgeon General to plan for the various aspects of such a wartime program (p. 29).

DISTRIBUTION AND UTILIZATION OF PSYCHIATRISTS

The proper distribution and utilization of neuropsychiatrists was one of the first problems facing the newly formed Neuropsychiatry Branch in 1942. This problem was intensified by the rapid expansion of the Army, which made it necessary for practically all Regular Army neuropsychiatrists to assume administrative and command assignments (p. 18), leaving psychiatric services without adequately qualified personnel.

In the haste to organize an army quickly, Reserve officers in the Medical Department were called to active duty and, often, without regard to specialized training,[1] were assigned merely as physicians. Consequently, many psychiatrists were assigned to medical duties other than psychiatric, in spite of the fact that there was a serious shortage of officers qualified in this specialty.

To remedy this situation and to effect the desired distribution and utilization of this category of personnel, a card index was compiled, of the

[1] In 1942, the Surgeon General's Office did not have a current list of civilian psychiatrists even though, in May 1939, the Council of the American Psychiatric Association, foreseeing the need for such information, appointed a committee on military mobilization with Dr. Henry A. Steckel, Chairman, to make "* * * a survey of available personnel (NP)." On 16 October 1939, this committee met with The Surgeon General and presented a list of its findings. This list was also made available to the National Research Council.

psychiatrists in the Army, giving such information as name, rank, organization, and duties, if known. Also, until the officer could demonstrate his ability, a professional rating, as listed by a special committee of the National Research Council, was used as the basis of his assignment. This rating list, drawn up by a group of leading psychiatrists, utilized the numerals I, II, III, and IV, as follows:

Group I consisted of outstanding specialists, well known nationally and internationally, who were competent to act at the consultant level.

Group II were neuropsychiatrists whose training and experience were sufficient to enable them to direct a hospital or service without professional supervision.

Group III were judged able to perform with a minimum of supervision.

Group IV required constant supervision.

Shortage of Psychiatrists

Even assuming proper assignment, there remained a serious shortage of adequately trained and qualified personnel. On completion of a survey on 13 August 1942, a total of 561 psychiatrists were found in the Army. Of these, only 51 were certified in psychiatry by the American Board of Psychiatry and Neurology; 38 in both psychiatry and neurology, and 4 in neurology. At the end of 1942, a total of 1,235 were listed in the files. Of these, 105 were certified in psychiatry, 89 in both psychiatry and neurology, and 16 in neurology. Many of the total number were psychiatrists only by virtue of their assignment to a psychiatric ward rather than their professional training and experience.

With so serious a shortage of well-qualified men and with the Medical Department expanding rapidly, including the fixed and numbered general hospitals and training centers, the Neuropsychiatry Branch was faced with the serious problem of not being able to place one qualified psychiatrist in each unit requiring psychiatric service.

Procurement

In an attempt to overcome these shortages, in May 1943, the Neuropsychiatry Branch wrote personal letters to over 100 neuropsychiatrists on the list of those certified by the American Board of Psychiatry and Neurology, stating the urgent need for men of their qualifications. A mere handful of replies, saying that the writers were in essential positions, was received. No psychiatrist was obtained through the medium of these letters. Some of these men preferred service in the Navy, Army Air Forces, or other Government agencies, such as the U.S. Public Health Service and U.S. Coast Guard, because of the poor publicity regarding

proper assignment, poor personnel practices, and poor morale of psychiatrists in the Army.[2]

School of Military Neuropsychiatry.—Because prewar psychiatry was largely limited to institutions, the civilian pool was soon exhausted, and it became apparent that the Army would be compelled to train medical officers in order to meet the demand. Accordingly, the School of Military Neuropsychiatry [3] was established. Its primary function, in the beginning, was to offer an opportunity for review and military orientation to newly joined, already trained or experienced, psychiatrists and neurologists. Later, it became an intensive training center in psychiatry and neurology for general medical officers to function, subsequently, as neuropsychiatrists.

The first class was enrolled on 20 December 1942, and by V–J Day, a total of 1,000 had been graduated. Without the graduates of this school, the work of psychiatry in the Army could not have been accomplished. Their enthusiasm, lack of prejudices, and, for the most part, freedom from self-esteem needs made them excellent assistants. Indeed, they were welcomed by the various psychiatric consultants who believed that for military purposes it was a good thing to receive young men with drive who did not need to "unlearn" certain civilian attitudes and practices, but who could be molded to function as psychiatrists in the Military Establishment.

Although the graduation of medical officers from the school to a limited extent met the need for neuropsychiatric ward officers, the graduates were handicapped by lack of experience and needed supervision by mature men. For this reason, the relatively few experienced psychiatrists found their time largely consumed by board meetings, paperwork, and supervisory duties, leaving but little or no time for them to actually treat patients.

CLASSIFICATION AND ASSIGNMENT

Classification

The professional classification of psychiatrists by the National Research Council (p. 42), while most helpful in the early stages of the war, soon became antiquated, for the original ratings did not reflect the further professional development of the psychiatrists. However, professional classification in all medical specialties was in the process of receiving considerable attention from the Personnel Service of the Surgeon General's Office. Various criteria were used, and finally, definitions of medical officer pro-

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[2] In January 1942, one of the country's leading civilian psychiatrists, Dr. Edward A. Strecker, had been asked by Maj. Gen. James C. Magee, The Surgeon General, to come on active duty and direct the Army's neuropsychiatric program. One of the chief reasons for Dr. Strecker's refusal of this offer was General Magee's lack of authority to control assignment of psychiatrists. (Personal communication from Dr. Calvin S. Drayer.)

[3] School of Military Neuropsychiatry, established at Lawson General Hospital, Ga., on 20 December 1942; moved to Mason General Hospital, Long Island, N.Y., in October 1943; Col. William C. Porter, MC, Director.

fessional capabilities, including psychiatrists, were published in WD (War Department) Circular No. 232, issued on 10 July 1944. Included in the definitions were the letters A, B, C, and D to indicate the degree of training and professional proficiency of the officer.

Since professional consultants had already been appointed to the various service and oversea commands, these consultants could now use the standards as set forth in the circular of 10 July 1944 to evaluate the professional ability of the medical officers, as observed personally. The function of the psychiatrists having changed considerably during the war, this evaluation served several purposes, not the least of which was transfer to a higher classification or change of an initial classification which definitely had been inadequate.

Assignment and Misassignment

Throughout the war, constant effort was required to maintain psychiatrists, especially younger men and graduates of the School of Military Neuropsychiatry, in neuropsychiatric work. As the war progressed, and more and more medical officers were required for combat units, these young psychiatrists were often lost to neuropsychiatry by their assignment to combat units. This was of such frequent occurrence that one officer in the Surgeon General's Office spent a considerable portion of his time trying to counteract this practice.

Constant liaison with the Personnel Service, SGO, and insistence that these officers be returned to neuropsychiatric work was required. But, once assigned to a Ground Forces unit or to a "hot outfit" alerted for oversea movement, the psychiatrist was often lost so far as functioning in neuropsychiatry was concerned. Not infrequently, the Surgeon General's Office received information from various sources, concerning misassignment of psychiatrists, often from the officers themselves who assumed that The Surgeon General had authority to take action on such matters. Because of decentralization of control, however, The Surgeon General had no assignment jurisdiction over medical officers in the Army Ground Forces, the Army Air Forces, or in any oversea theater.[4] Consequently, even though the need for trained men was tremendous, The Surgeon General was often powerless to effect proper use of these specialists. Thus, the situation resembled that of a fire department which procures and pumps water through its hose but is denied the right to direct the nozzle at the fire.

Control of assignment.—As the war went on, it became obvious that the control of assignment and reassignment of key individuals must be centered in the hands of the chief consultant in neuropsychiatry who was responsible to The Surgeon General for the care and treatment of neuropsychiatric patients. On 12 May 1944, ASF (Army Service Forces)

[4] For a discussion on decentralization of personnel administration, *see* Medical Department, United States Army. Personnel in World War II. Washington: U.S. Government Printing Office, 1963, pp. 21–25.

Circular No. 138 was issued, which charged The Surgeon General with "the responsibilities for distribution of Medical Corps officers and nurses among the various major organizational elements of the Army Service Forces." The circular empowered The Surgeon General to "direct * * * required transfers of Medical Corps officers, by qualifications * * * between commands to effect * * * readjustment." Further, The Surgeon General was authorized to effect transfers of "key" personnel by name. The circular further provided that "* * * commanders will be directed to take corrective action when the staff assigned does not meet required standards or is not properly utilized."

Since the various service command psychiatric consultants and psychitric consultants in oversea theaters had begun exercising strong influence in personnel matters in their headquarters, a neuropsychiatrist was seldom transferred without their concurrence. These consultants, however, worked in close liaison with the Neuropsychiatry Consultants Division. After the middle of 1944, no assignments or allotments of neuropsychiatrists were made by the Personnel Service without concurrence from the Neuropsychiatry Consultants Division. It should be understood that, while the Personnel Service could assign officers to a unit, theater, or service command, their subsequent careers and assignments were influenced by the theater or service command psychiatric consultant. Therefore, close liaison between the various consultants in the Neuropsychiatry Consultants Division was mandatory and fully attained in the latter part of World War II.

CONTINUED SHORTAGES

As the war continued, the need for qualified psychiatrists became even more acute, as the mission of psychiatry had changed considerably toward a more comprehensive program. This included emphasis upon prevention; requirements to retain and treat psychiatric casualties "as far forward as possible" both in combat and in mental hygiene centers at training camps; and, finally, the establishment of treatment and rehabilitation programs in Zone of Interior convalescent and fixed hospitals. It was therefore necessary to "spread" psychiatrists even more thinly than before.

In July 1944, at the Service Command Conference, Fort Leonard Wood, Mo., Lt. Gen. Brehon B. Somervell, Commanding General, ASF, who had learned of the critical shortages of the various categories of neuropsychiatric personnel, directed The Surgeon General to procure and train sufficient psychiatrists and psychologists to meet the overall need of the Army.

To comply with General Somervell's order, The Surgeon General requested Col. (later Brig. Gen.) William C. Menninger, MC, Director, Neuropsychiatry Division, for all pertinent information on the procuring and training of neuropsychiatrists and clinical psychologists. In reply to this request, Colonel Menninger, in a memorandum of 1 August 1944, furnished

the desired information to The Surgeon General. On 4 August, The Surgeon General relayed this information to the Commanding General, ASF, in part, as follows:

A. *Psychiatrists.*

* * * we can expect few, if any, additional qualified psychiatrists from civilian life. Repeated efforts have been made from this Office to secure the services of additional civilian neuropsychiatrists and various appeals have been made by the American Psychiatric Association. It is estimated that approximately 26 percent of the membership of the American Psychiatric Association are now in the military service. These men do not need training.

* * * it has been necessary to provide training in basic psychiatry and neurology for newly commissioned interns * * * 70 being trained at the School of Military Neuropsychiatry, 40 at Columbia University, and 30 at New York University.

* * * 53 student officers are being trained at the School of Neuropsychiatry at Mason General Hospital * * * approximately 15 are newly commissioned medical officers.

* * * for the present and contemplated requirements for the services of neuropsychiatrists in the Zone of Interior and for proposed numbered units in 1944, * * * 1,060 such medical officers will be required * * * there are available * * * approximately 765 qualified officers, leaving a shortage of approximately 295 psychiatrists in the ZI.

B. *Psychologists.*

* * * 58 Clinical Psychologists are assigned to Army Hospitals in the Zone of Interior, and 63 are assigned to Induction Centers.

* * * survey is being made among enlisted men with the view of commissioning those with adequate qualifications. * * * believe that a sufficient number of psychologists can be commissioned from enlisted men to meet immediate needs in the Zone of Interior hospital installations.

The question of training of Clinical Psychologists is being given consideration * * * whether "on the job" training in hospitals will be utilized or whether the training will be taken over by the Adjutant General's School.

Although by July 1944, a total of 1,490 medical officers were listed as psychiatrists, it was more noticeable than ever that the majority of these men were merely psychiatrists "by command." Of this group, only 136 were certified in psychiatry, 121 in neurology and psychiatry, and 14 in neurology. Another attempt was therefore made to secure these specialists from civilian sources.

On 12 August 1944, the Chief, Personnel Service, at the request of the Director, Neuropsychiatry Consultants Division, with the approval of The Surgeon General, formally requested the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, of the War Manpower Commission, to increase the number of civilian psychiatrists as available for appointment in the Medical Corps of the Army. This letter was answered on 31 August 1944. The reply acknowledged receipt of the request and promised to present it before the Directing Board at the board's 23 September 1944 meeting. However, it called attention to the fact that the shortage of psychiatrists was also acute in civil life and that a balance must be observed between the Armed Forces and the civilian population.

On 14 October 1944, a further communication from the Procurement and Assignment Service stated that its Directing Board had called the Army's needs to the attention of the various State chairmen who, pre-

sumably, would declare available any psychiatrist who could be spared from civilian life.

To give The Surgeon General wider latitude in assignment authority, General Somervell, in a 17 August 1944 memorandum to The Surgeon General, on the subject "Assignment of Neuropsychiatrists and Clinical Psychologists," stated: "It is desired that, pending the availability of a sufficient number, steps be taken by you * * * to assure the assignment of these individuals to positions where their services can be best utilized and are most urgently needed."

As has been indicated, by the time it was recognized that modern warfare produced a flood of neuropsychiatric casualties, the breach between requirements for psychiatrists and available supply was so great that it was never closed.

Understaffing

It was not uncommon for a psychiatrist to be responsible for a hundred or more patients on his wards at any one time, while medical officers on other clinical services, not infrequently, found their time not fully occupied. Many combat divisions overseas were forced to designate an inexperienced medical officer as the division psychiatrist because of the unavailability of trained neuropsychiatrists. Special neuropsychiatric treatment centers and hospitals also found it necessary, in many instances, to use general medical officers as psychiatric ward officers. Training center mental hygiene units, reconditioning centers, hospital ships, redistribution centers, and separation centers were all understaffed as far as psychiatrists were concerned. Similarly, the Ground Forces early in 1944 pointed out that nondivisional ground force troops had not been provided with neuropsychiatrists. A tentative plan was drawn up providing for mobile neuropsychiatric units for these troops, but because of the personnel shortage, the plan was never activated.

Staffing Inequities

By the spring of 1945, the shortages and maldistribution created severe staffing inequities. For instance, the Second Service Command had only 30 percent of the number of psychiatrists required, while the Seventh Service Command had 70 percent of its requirement. This excessive deficiency in the Second Service Command was due to the doubling of the bed capacity of Mason General Hospital, Brentwood, Long Island, N.Y., and to the activation of a large convalescent hospital at Camp Upton, N.Y., without the assignment of additional psychiatrists.

Similar deficiencies due to personnel shortages existed in other service commands, but the larger ones could absorb them more easily than could the smaller ones.

The unavailability of personnel was not, however, the only reason for staffing inequities; another was the lack of adequate information in the Surgeon General's Office concerning service command requirements. The need to correct improper distribution led to the practice of surveying the various commands before the graduation of a class from the School of Military Neuropsychiatry and of assigning graduates in proportion to the needs of each command.

The need for more medical officers on neuropsychiatric wards became so acute that, on 26 May 1945, ASF Circular No. 189, pointed out this fact and stated:

> It is desired that the commanding generals of service commands and the Chief of Transportation make every effort to supplement neuropsychiatric services and sections at medical installations under their control when it has been determined that those services or sections are understaffed.
>
> Apparent shortages will be met to the extent practicable, by the reassignment of carefully selected general duty medical officers, SSN 3100.
>
> Special consideration will be given * * * to the temporary assignment of any grade D specialist at times when his services are not required in the performance of duties pertaining to his permanent assignment.

Summary

A recheck of the number of neuropsychiatrists in the Army was made on 21 October 1944. The following results were obtained:

There were a total of 1,895 on duty, of whom 18 were classified as A; 344, as B; 580, as C; and 853, as D.

This total was a striking increase over the 1,235 as of the end of 1942 (p. 42), due in the main, to the addition of graduates of the School of Military Neuropsychiatry. In spite of this increase, however, there still was a critical shortage of psychiatrists.

In November 1944, another survey was made, and according to the figures supplied by the Military Personnel Division, SGO, 1,063 psychiatrists were needed for Zone of Interior installations alone, to meet minimum standards as set forth in manning tables. Only 651 were available. Thus, there was a shortage of 412 psychiatrists, not including the needs for oversea installations, redistribution centers, retraining centers, rehabilitation centers, and units scheduled to be activated for oversea shipment. Requests were therefore made and granted that the School of Military Neuropsychiatry be enlarged (p. 56), since the only source of officers with neuropsychiatric experience of any type would be interns who had entered the service and had had a brief course of military indoctrination. The increases derived from this source were evident in the following results of a survey made on V–E Day, 8 May 1945: There were a total of 2,402 military neuropsychiatrists of whom 422 were classified as either A or B; 729, as C; and 1,251, as D. It is obvious from these figures that strenuous

efforts were made to alleviate the shortage. Nevertheless, it was not possible to even approximate the needs.

PSYCHIATRIC WORKLOAD VERSUS PSYCHIATRIC MANPOWER

A graphic picture of the situation as regards neuropsychiatric personnel can perhaps best be had by quoting the following excerpt from a statement given at a conference at Percy Jones General Hospital, Battle Creek, Mich., on 21 August 1945, by Dr. Eli Ginzberg, Director, Resources Analysis Division, the Surgeon General's Office:

There were available on V–E Day a total of 2,402 Medical Corps officers with a military occupational classification "neuropsychiatrist," to treat and dispose of this patient load. This disregards for the moment the many who were not available to treat patients because their work was concerned with processing personnel, courts-martial, and training. The foregoing wording is cautious and deliberately so, because it is important to realize that about half of the total group were "90–day wonders"—mostly young doctors who volunteered for or were assigned to an intensive 90-day course after which they were reclassified as psychiatrists.

The 1,200 doctors who were classified as psychiatrists at the time when they were commissioned warrant further analysis. For the most part, these psychiatrists had been employed in State institutions where they were concerned primarily with the care of psychotic patients. The Army always has some psychotic patients—about 10 percent of the total psychiatric load—but the center of gravity in the military is the patient suffering from neurotic and other personality difficulties. Hence, most psychiatrists commissioned directly from civilian life had much to adjust to, when they went into uniform. The scale of the Army's training program for psychiatrists which resulted in doubling the available supply—at least statistically—was an achievement without parallel in medical training during World War II.

If all of the 2,400 psychiatrists were treating patients on V–E Day, a doctor-patient ratio of approximately 1 to 23 would have existed.

For contrast, the following figures will prove helpful. At the time when there were 55,000 psychiatric patients in Army hospitals, there were approximately 250,000 surgical patients. To handle this surgical load, the Army had available about 10,000 surgical specialists, most of whom had been specialists in civilian life. In addition, there were assigned large numbers of "general duty" officers, many of whom had completed surgical internships. The ratio of surgeons to surgical patients was probably 1 to 10.

On the medical side there were on V–E Day about 240,000 medical patients. Available to treat these patients were 6,000 specialists in internal medicine, cardiology, gastroenterology, and allied specialties, and a sufficiently large number of "general duty" medical officers to establish a ratio of approximately 1 to 15, perhaps 1 to 12.

The foregoing ratios understate psychiatry's handicap because psychiatric patients usually require more doctor's time than medical or surgical patients. However, a smaller percentage of neuropsychiatrists were engaged in patient treatment than surgeons and internists; large numbers were occupied in other essential work.

During the first 6 months of 1945 when patients evacuated from overseas reached a wartime peak, there were actually more neuropsychiatric patients than medical patients returned from the Pacific. The significance of this statement is highlighted when one realized that the Pacific evacuated a larger percentage of patients for disease than any other theater. During this same period the number of patients evacuated for neuropsychiatric disorders from the European theater almost equaled the number evacuated for disease.

The most startling figures are those becoming available with the publication of the medical histories of the field armies. The experiences of the First U.S. Army—which accounted for most of the American fighting strength during the first 2 months after D-day in France—have been published. During these 2 months, nine divisions can be considered to have been actively engaged. The records of these divisions reveal that there was one neuropsychiatric admission out of every two medical admissions. In certain divisions, the admissions for neuropsychiatric causes swamped all other medical admissions. This can be illustrated by pointing to one division which had a per annum rate of 944 neuropsychiatric admissions out of 1,100 total medical admissions. In nonstatistical terms, this means that the entire strength of the division would have been dissipated within a year as a result of psychiatric casualties if men had not been treated and returned to duty.

In the other light divisions, neuropsychiatric admissions amounted to 200 out of a total of 482 medical admissions per annum or approximately 40 percent. If these psychiatric casualties had not been effectively treated, one-fifth of the entire divisional strength would have been lost during the course of a year.

What about surgery? In these nine fighting divisions there were 5.4 battle casualties for one neuropsychiatric casualty. It must be emphasized that many men classified as casualties were lightly wounded casualties.

Shifting from rates to absolute figures, the First U.S. Army reported, during June and July, 11,000 neuropsychiatric admissions, 16,000 admissions for disease, and 60,000 battle casualties, half of whom were classified as serious.

If D-day had come earlier, at a time when the Army had no detailed plans for the prevention, treatment, and assessment of psychiatric patients, the First U.S. Army would probably have lost most of these 11,000 admissions. Actually only 4,000 were lost. This means that approximately 60 percent of the men admitted for neuropsychiatric disorders were treated and returned to duty within the army area. The remaining 35 percent were evacuated to the rear. They were lost for combat but only 10 percent were lost for service in the theater. In contrast, medicine was able to salvage about 60 percent of its admissions while surgery succeeded in returning within the army area only 5,000 of the 60,000 wounded, or 9 percent.

In light of this experience, it should prove profitable to review the War Department planning for the distribution of medical means. Based upon current tables of organization, a field army composed of three corps with supporting troops is assigned approximately 1,500 Medical Corps officers. Of this number, the tables provide for 62 specialists in medicine. Experience indicates that approximately three "general duty" officers were assigned to medical work for each specialist or a total of 250 doctors in an army area. In the First U.S. Army, this group had to care for 16,000 disease admissions. The surgical staff amounted to 370 surgical specialists and about 600 "general duty" officers. The surgical workload totaled 60,000 patients. The remaining medical officers in the army area were assigned to evacuation, planning, and other operational work.

These same tables of organization provided for 26 neuropsychiatrists. In the First U.S. Army, their workload amounted to 11,000 admissions. Theater surgeons, recognizing on the basis of past experience the gross discrepancy between means and requirements, rose to the challenge as best they could by training battalion surgeons and by scraping together psychiatrists who could be spared from duties in the Communications Zone and bringing them forward to the army area where the challenge was greatest.

By improvisation, by hard work, by careful control over the evacuation system, the 26 Army psychiatrists, assisted by whatever the theater surgeon was able to spare, succeeded in returning to duty 40 percent of all admissions directly from the clearing stations and other forward units. Another 25 percent was returned to duty from evacuation and convalescent hospitals in the army area. As had been pointed out

before, 35 percent of the original admissions had to be evacuated to the Communications Zone, but only 1 man in 10 was lost to the theater.

CONCLUSION

The defeat of Germany in 1945, making possible the return of a number of capable, experienced personnel to the Zone of Interior for duty, permitted the release of a number of like officers from the Zone of Interior to the Pacific theaters, so that by V–J Day, the personnel requirements had been nearly approximated by the available men.

While the lack of preparation, along with inadequate numbers of personnel and facilities, makes this chapter a recital of work performed under severe handicaps, it is also apparent from the psychiatric manpower analysis, presented by Ginzberg, that surprisingly good results were obtained by a limited number of psychiatric personnel utilizing appropriate methods of management and treatment.

CHAPTER IV

Education and Training

William C. Menninger, M.D.

NEED FOR TRAINING IN MILITARY PSYCHIATRY

Three factors led to placing a major emphasis on the educational and training aspects of the neuropsychiatric program in the Army—the insufficient number of specialists in neuropsychiatry in the Army, the persisting nationwide shortage of psychiatrists, and the inadequacy of training in psychiatry in civilian medical schools.

The Regular Army had a minimum of trained men in the field of neuropsychiatry (p. 41), only four of whom had been certified by the American Board of Psychiatry and Neurology, and two of these were approved by credentials because of age.[1] With the exception of a few previously mentioned (p. 18), most of the Regular Army psychiatrists were used in administrative capacities, though some of these assignments were related to psychiatry. To direct its wartime psychiatric program, the Army had to recruit specialists from an already insufficient number of civilian specialists. In civilian life, psychiatrists had never constituted more than 2 percent of the practicing physicians, and approximately 80 percent of these were concerned with institutional work, mainly in State hospitals. The corresponding type of work in the Army, namely, with psychotic patients, constituted less than 10 percent of the total psychiatric service, although the incidence of psychosis was not greatly different from that in civilian life One might conclude that psychiatric practice in the Army was proportionately 10 times as extensive as in average civilian community practice, if limited to institutional work. Consequently, even initially, there was an acute shortage of neuropsychiatrists, and this was more of a problem in view of the comparatively large number of physicians whose experience had been limited to work with psychoses.

A second factor, inseparably linked with the shortage of psychiatrists, was the very rapid increase in psychiatric casualties. Within the first year of the war, the job of providing care for these casualties grew to extensive proportions and, as the magnitude increased, the relative shortage increased also.

A third factor resulted because of the inadequate training in psychia-

[1] Col. Cleve C. Odom, MC, and Col. William C. Porter, MC.

try in the average medical school. It is an admitted fact that the majority of medical students, at the time, graduated without any clear understanding of the anatomy, the physiology, and the pathology of the psyche. Consequently, it was impractical merely to assign younger medical officers or general practitioners to the overworked neuropsychiatric sections in hospitals, although necessity required this in many instances. It was not uncommon to find a surgeon or an obstetrician who had had a year of State hospital work immediately after graduation, followed by training and the practice of his own specialty for 10 years or more, assigned to the psychiatric section of the hospital. Furthermore, it was recognized that, even though a man might be a well-qualified psychiatrist, an important aspect of his Army psychiatry necessitated his learning the administrative aspects concerned with the field, such as Army regulations dealing with psychiatry, methods and procedures in dispositions, testimony before boards, courts-martial testimony, and current policies as given in circulars and manuals.

Just as in all other phases and aspects of psychiatry, no prewar plans had been made for psychiatric indoctrination or education. The evolution of the educational efforts again illustrates the struggle in which each step taken was an attempt to meet an emergency and a very critical problem. Many of the eventual progressive moves could not have been planned, even at the onset of the war, and, in almost every instance, there was only manpower and time to attack the most acute and immediate problem. It probably will be repeated here and elsewhere that the lessons learned in World War I and recorded for posterity [2] went unheeded. This indictment cannot go unchallenged because the actual interpretations of the lessons learned varied with the individual who interpreted them. So, heeded or unheeded, the problems that arose had to be solved when they presented themselves in World War II.

Within 6 months after Pearl Harbor, the Neuropsychiatry Branch (later the Neuropsychiatry Consultants Division), SGO (Surgeon General's Office), became aware of the national shortage of trained psychiatric potential for the Army and of the need for intensive training in this field. Consequently, after investigating this aspect of military manpower, the chief of the branch submitted a memorandum to the chief of the Professional Service, SGO, recommending that training courses in military neuropsychiatry be established.[3] This memorandum brought out several pertinent points of reasoning. First, it brought out the increase in neuropsychiatric disorders already recognized at this early date. Second, it focused on the inexperience of newly recruited medical officers to the "mental disorders peculiar to military life." Third, it recognized the difficult transi-

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[2] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X.

[3] Memorandum, Col. Roy D. Halloran, MC, and Maj. Malcolm J. Farrell, MC, for Brig. Gen. Charles C. Hillman, 1 Sept. 1942, subject: Training Courses in Military Neuropsychiatry for Medical Officers.

tion of many psychiatrists from civil to military life "without assistance." Fourth, it heralded the need to amalgamate the varied thoughts of psychiatrists and psychiatric schools of thought into a uniform, single, acceptable form of military neuropsychiatry. Fifth, it anticipated the advent of "more serious problems of forward combatant areas, for which many will have no preparation."

The memorandum contained the proposal that Col. William C. Porter, MC, then Chief, Neuropsychiatry Section, Walter Reed General Hospital, direct this teaching and training program at the Walter Reed Army Medical Center, Washington, D.C. The course was to last from 4 to 6 weeks and was to be established primarily to orient those psychiatrists who had come from civilian life to the peculiar military aspects of psychiatry so that they could promptly function more efficiently and in a uniform manner. The memorandum further spelled out the required staff of the school which was a modest estimate of four instructors, including the director. It also presented the novel idea that the teaching team could later move to various Army centers to instruct medical officers in the surrounding areas. Supplementation of the team by service command consultants and prominent civilian specialists was also recommended.

THE SCHOOL OF MILITARY NEUROPSYCHIATRY

With only tentative approval gained, plans were started for the development of a 4-week course in military neuropsychiatry, limited to those medical officers who had at least 1 year's training or experience in psychiatry or neurology, or both. Colonel Porter, as recommended, was designated director of "The School of Military Neuropsychiatry" and was to remain in this assignment throughout the war. However, prior to this assignment, Colonel Porter was actively engaged in the training of psychiatrists at Walter Reed. Official approval was eventually obtained from The Adjutant General,[4] and the school was organized and began functioning on 20 December 1942 at Lawson General Hospital, Atlanta, Ga. Here, Brig. Gen. William L. Sheep, a Regular Army psychiatrist, was the commanding general, and Lt. Col. Joseph S. Skobba, MC, was the chief of the Neuropsychiatric Section. Their active and gracious collaboration greatly facilitated the teaching program of the school. The first nine courses, including, on an average, 30 students each, were conducted at Lawson General Hospital, and the course was specifically planned to orient the trained or experienced psychiatrist and neurologist to the practice of military neuropsychiatry.

[4] War Department Memorandum No. W350–134–42, 4 Dec. 1942.

Later Changes

In October 1943, the school was moved to Mason General Hospital, Brentwood, Long Island, N.Y. Mason General Hospital had been designated as a specialized treatment hospital for neuropsychiatric casualties, and it was believed that the training program could take advantage of the increased clinical facilities. As indicated previously, the initial plan was to orient psychiatrists who came into the Army directly to their military assignment. Over 400 of the psychiatrists coming into the Army from civilian life had the advantage of this course. In the spring of 1944, it was apparent that the acute shortage of trained psychiatrists would continue so the general program of the school was reoriented to provide a 12- instead of a 4-week course for intensive training of medical officers who had had no previous psychiatric experience. With the exception of the two "fill-in" courses of 6 weeks, this latter plan was continued at Mason General Hospital until 22 December 1945, when the 23d and last class graduated.

The inclusive dates of the last 12 courses and the number of graduates are listed in the following tabulation:

Inclusive dates	*Number of graduates*
20 December 1943–15 January 1944	26
17 January 1944–12 February 1944	27
14 February 1944–11 March 1944	28
13 March 1944–8 April 1944	27
15 April 1944–8 July 1944	70
10 July 1944–30 September 1944	58
2 October 1944–11 November 1944	69
20 November 1944–10 February 1945	70
19 February 1945–12 May 1945	93
21 May 1945–30 June 1945	84
9 July 1945–27 September 1945	101
8 October 1945–22 December 1945	39
Total	692

Since 308 students had completed the first 11 courses and 692 the last 12 courses, exactly 1,000 students were trained.

Program of Instruction

The approved master schedule for the 600 hours (12 weeks' course) and 300 hours (6 weeks' course) included the following subjects:

	Hours	
	12 weeks' course	*6 weeks' course*
Basic military training	98	61
Review of neuroanatomy, physiology, and pathology	36	19
Clinical neurology	92	40
Clinical psychiatry (emphasis on borderline and minor psychiatric deviations)	309	152
Special Army problems	27	12
Psychological testing	18	6
Reserved by commandant for special speakers	20	10
Total	600	300

In carrying out the training, an absolute minimum number of didactic lectures had to be given in order to meet the requirements as approved by the War Department.[5] Applicatory exercises in the form of clinical clerkships and critiques were the important features of the course. In addition, demonstrations were freely used, and conferences consisting of roundtables, forums, and informal discussions were irregularly included.

MILITARY PSYCHIATRIC TRAINING IN CIVILIAN SCHOOLS

The pressure to obtain a greater number of embryonic neuropsychiatrists at a faster speed resulted in arrangements to institute a similar course in civilian installations. The director of the Neuropsychiatry Consultants Division was given authority to contact four medical schools in New York City, and arrangements were satisfactorily made with Columbia University and New York University to provide the 600-hour, 12 weeks' course. Both of these universities did conduct three such courses.

The first class was conducted from 15 April 1944 to 8 July 1944, with 39 officers completing at Columbia University and 28 at New York University; the second class was from 18 November to 10 February 1945, with 34 officers completing at Columbia University and 29 at New York University; the third class was from 1 September to 24 November 1945, with 47 officers completing at Columbia University and 50 at New York University. Dr. Nolan D. C. Lewis was directly in charge of the classes at Columbia Uni-

[5] The list of the instructors at Lawson and Mason General Hospitals with rank held at time of assignment is as follows: Col. William C. Porter, MC, Director, 15 Dec. 1942–31 Dec. 1945; Lt. Col. M. Ralph Kaufman, MC, 15 Dec. 1942–30 Aug. 1943; Maj. Joseph Fetterman, MC, 15 Dec. 1942–11 Mar. 1944; Maj. William H. Everts, MC, 17 Dec. 1942–1 Oct. 1943; Maj. James L. O'Leary, MC, 10 Oct. 1943–22 Dec. 1945; Maj. Jackson M. Thomas, MC, 6 Sept. 1943–4 June 1944; Lt. Col. Baldwin L. Keyes, MC, 1 May 1944–11 Nov. 1945; Lt. Col. Ralph T. Collins, MC, 10 Apr. 1944–22 Dec. 1945; Capt. (later Maj.) Herbert Spiegel, MC, 28 Aug. 1944–22 Dec. 1945; Maj. Henry A. Davidson, MC, 26 Feb. 1945–15 Dec. 1945; Capt. Leonard R. Sillman, MC, 10 June 1944–1 Mar. 1945; Maj. William H. Dunn, MC, 5 June 1944–30 Aug. 1944; Maj. Benjamin H. Balser, MC, 18 Nov. 1943–9 Apr. 1944.

versity, and Dr. S. Bernard Wortis was in charge at New York University. Instruction was provided by the faculties of these two universities. Maj. Norman Reider, MC, was placed on temporary duty by the Medical Department to serve as coordinator for these classes and to give the lectures on strictly military subjects. He was assisted by 1st Lt. (later Capt.) Bernard J. Lamb, MAC, in the first two classes.

WHAT THE SCHOOLS ACCOMPLISHED

The value of this training in neuropsychiatry was inestimable. The schools, at Lawson and Mason General Hospitals combined, graduated 1,000 men. The university schools graduated 227. At least two-thirds of the total number had no previous psychiatric training, other than the minimal lecture courses given in medical schools. Although they could only be classified as "D" specialists (in a ranking A, B, C, and D classification), they tremendously augmented the neuropsychiatric staffs of the medical installations throughout the Army. There is abundant evidence, obtained from observation by experienced psychiatrists, that these men did a very creditable job and that the relatively short training did give them a functional orientation which permitted them to do good psychiatry on their assignments. Since the majority had been general practitioners in civil life, they not only maintained a trained eye on possible organic disturbances, but also became acutely aware of the existence of psychological concomitants as well as purely psychological illness. By their recent alliance with medicine, their eagerness to learn, and the judicious application of their learning in a field quite new to them, they materially assisted in mounting liaison between psychiatry and the other fields of medicine. This training program was regarded as one of the most important and successful achievements during the war to meet the overwhelming neuropsychiatric problem in the Army. After the war, many of these men had become so interested in the specialty, that they entered psychiatric residencies and thus swelled the ranks of psychiatrists, so sorely needed throughout the country.

Recognizing that the School of Military Neuropsychiatry had been such an essential training project, the Training Division, SGO, when asked to reduce to a minimum the training activities following V–J Day, recommended continuation of this school indefinitely among the very few medical training units to be preserved. Looking forward to the postwar Regular Army training program, the school was officially moved to Fort Sam Houston, Tex., on 1 June 1946, to be associated with the Brooke Army Medical Center at that post, in orders issued from the Headquarters of the Second Service Command, 10 January 1946.

PSYCHIATRIC TRAINING IN OVERSEA THEATERS

By force of necessity, neuropsychiatrists were trained in all the major oversea theaters. In some locations, formal training courses in specific medical units were established and trainees were assigned on orders. Some training, because of the exigencies of the tactical situation, had to be done on the job; sometimes, under enemy fire; and at times, meetings or "bull sessions" served to exchange experience procedures and methods in psychiatric care. The training in the oversea theaters is detailed in the sections relating to these various areas.

European theater.—Two special efforts of many, one in the European theater and one in the South Pacific Area, are worthy of mention. In the European theater, the 312th Station Hospital (NP) made training one of its major activities. This was largely organized through the efforts of the theater Senior Consultant in Neuropsychiatry, Col. Lloyd J. Thompson, MC (fig. 10), with the help of the commanding officer of the hospital, Col. Ernest H. Parsons, MC (fig. 11). A school of military neuropsychiatry was organized under the immediate direction of Maj. (later Lt. Col.)

FIGURE 10.—Col. Lloyd J. Thompson, MC, Senior Consultant in Neuropsychiatry, Office of the Chief Surgeon, European Theater of Operations, U.S. Army.

Jackson M. Thomas, MC (fig. 12), who was later succeeded by Maj. Howard D. Fabing, MC. Training for general medical officers was also given at the 36th Station Hospital (NP) in June and again in November and December 1943.

The training program for general medical officers of combat units was given continuously at the 312th Station Hospital (NP) from 27 December 1943 to 15 July 1944. The prepared course was of 1 week's duration, and during this time interval, 768 general medical officers attended the school. Again and again, the officers assigned began the course with skepticism and indifference and almost invariably ended with enthusiasm and appreciation. The primary aim was to instruct these officers in the recognition and first aid management of psychiatric battle casualties, since the majority of the group were to serve with combat troops. The effort of this school in orienting, psychiatrically, this large number of medical officers was probably one of the most significant factors in the low rate of evacuation of psychiatric casualties from the European theater.

South Pacific Area.—In the South Pacific Area, two formal schools were held, one for the 27th Infantry Division and one for the 81st Infantry Division. The school for the 27th Infantry Division was held from 1

FIGURE 11.—Col. Ernest H. Parsons, MC, Commanding Officer, 312th Station Hospital (NP), European Theater of Operations, U.S. Army.

FIGURE 12.—Maj. (later Lt. Col.) Jackson M. Thomas, MC, Director, School of Military Neuropsychiatry, European Theater of Operations, U.S. Army.

January 1945 to 31 January 1945 at Espíritu Santo in conjunction with the 25th Evacuation Hospital and the 122d Station Hospital. The courses were organized under the direction of Lt. Col. (later Col.) M. Ralph Kaufman, MC (fig. 13), and Lt. Col. (later Col.) Edward G. Billings, MC (fig. 14). In addition to providing the instruction for 32 medical officers, 13 chaplains were given psychiatric orientation, 99 selected line officers attended five lectures, and all officers of the division, totaling 225, attended one general session.

The school for the 81st Infantry Division under Colonel Billings was held from 12 February 1945 to 10 March 1945 and utilized the 8th and 29th General Hospitals. Sixty-seven medical officers and seventeen chaplains were given training at these courses. One session was held for all officers of the division, totaling 300 men.

TRAINING OF PARAMEDICAL PSYCHIATRIC PERSONNEL

The training of nurses, psychologists, psychiatric social workers, neuropsychiatric technicians, and aids is detailed in respective chapters

FIGURE 13.—Lt. Col. (later Col.) M. Ralph Kaufman, MC, Neuropsychiatric Consultant, South Pacific Base Command.

dealing with these paramedical personnel, and likewise, oversea efforts at training are described in the respective theater histories.

PSYCHIATRIC EDUCATION OF GENERAL MEDICAL OFFICERS

There is little doubt that the psychiatric casualty rate both in combat and in noncombat conditions reflected in some degree misunderstanding between the line and medical officers. A fair percentage of line officers had no understanding of psychopathology. They did not want to be bothered with noneffective soldiers. They learned that one of the convenient methods of getting rid of these soldiers was to refer them to the Medical Department. On the other hand, comparatively few medical officers had had field duty, either combat or otherwise. They did not always clearly understand the problems confronting the line officer. When this factor was combined with lack of knowledge and understanding of psychiatric casualties because of faulty medical education, there is little doubt that the Medical Department contributed its share of disposing of psychiatric casualties who might have performed adequate duty.

FIGURE 14.—Lt. Col. (later Col.) Edward G. Billings, MC, Neuropsychiatric Consultant, South Pacific Area.

It was obvious to many thoughtful individuals that two major educational efforts should be made relating to psychiatry: First, to teach medical officers psychiatry and the most expeditious methods of providing psychiatric care to both combat and noncombat casualties; and second, to give the line officers a better understanding of the Medical Department's attitudes and aims toward these types of patients.

It would be impossible to portray adequately the extent of the educational effort that was put forth toward both of these aims. Most of it had to be done through personal and individual contact. Every consultant regarded these objectives as among his most important functions and, undoubtedly, spent a large proportion of his time in educating individuals in groups, through personal contact, conferences, meetings, and schools.

Efforts to indoctrinate general medical officers were a part of the efforts of the Surgeon General's Office and the service commands. The most tangible results were probably evident in the mental hygiene con-

sultation services and in each basic training camp through the office of the psychiatrist in charge of the mental hygiene consultation service. Six hours of psychiatric instruction were given to students at the Medical Field Service School, Carlisle Barracks, Pa., although this was never very satisfactory for lack of a suitable instructor. Because of the demand, WD (War Department) Technical Bulletin (TB MED) 94, "Neuropsychiatry for the General Medical Officer," was issued on 21 September 1944 and was widely disseminated. It was used as the basis for staff meetings, medical meetings, and seminars, and presumably a copy was given to every medical officer.

ORIENTATION IN MENTAL HEALTH

Formal Program

The desirability of giving all Army officers some understanding of mental hygiene concepts was recognized, particularly as it pertained to leadership and in the hope that such knowledge would reduce the number of psychiatric casualties. On this basis, the Neuropsychiatry Consultants Division was able to include in WD Circular No. 48, issued on 3 February 1944, the provision that 6 hours of lectures in mental hygiene be given to all Army officers. This circular also prescribed 3 hours on the same subject for all enlisted men. The publication of this circular was followed shortly by an outline of these prescribed lectures, the one for officers in TB MED 12, issued on 22 February 1944, and the one for enlisted men in TB MED 21, issued on 15 March 1944. The inclusion of these lectures moved so rapidly that the circular had to be written and printed before the Neuropsychiatry Consultants Division could complete the lecture outlines.

In obtaining approval for the program, much preliminary discussion was held with various echelons in the War Department as to terminology and number of lectures. Initially, the Neuropsychiatry Consultants Division recommended 10 hours for officers and 5 hours for enlisted men. For such a radical innovation, it was finally determined that 6 hours should be recommended for officers and 3 hours for enlisted men. In order to overcome prejudice, instead of using the term "mental hygiene," the title of "Personnel Adjustment" was used for the officers' lectures and "Personal Adjustment" for the enlisted men's lectures. Concurrence was readily obtained from the Army Ground Forces. It was delayed in being acted upon by the Army Service Forces and actually was approved by G–3 (operations and training) before final concurrence was obtained from the Army Service Forces. Both of these medical technical bulletins were entirely rewritten after the end of the war.

Problems Encountered

These lectures undoubtedly contributed to the mental health of the Army by removing some of the mystery connected with psychiatry and by properly explaining many of the misconceptions commonly connected with this specialty. It was, however, impossible to know just how extensively the lectures were actually used because no system of checking had been instituted. Many personal letters from all over the world indicated that they were being given. Consultants stressed their importance in every unit visited. The AGF (Army Ground Forces) headquarters and ASF (Army Service Forces) headquarters [6] sent specific instructions to all basic training camps to insure that the lectures would be given. Much of their effectiveness depended upon the amount of time the busy psychiatrist could spare in meeting the demands for these lectures and upon the ability of the psychiatrist to present such material in an impressive and instructive manner.

There was much dissatisfaction in some units because of the time involved in giving the lectures. In all the training camps, the training schedule was so full that it was with difficulty that they were included, and in a few instances, they had to be given in the soldiers' off-duty period. The circular as well as the medical technical bulletins also served the extremely important purpose of calling the attention of high ranking commanding officers to the War Department's recognition of the importance of this subject. In a few places, as illustrated by the schools in the South Pacific, the line officers en masse were exposed to psychiatric orientation. War Department Circular No. 48 came out over 2 years after the war began, and, during those 2 years, no official, centrally sponsored, psychiatric or mental hygiene orientation was given. Even after the circular and bulletins appeared, a large number of officers and troops were in forward areas and certainly never put the directive into effect. No psychiatric lectures were ever included in the Infantry Officers' Training School at Fort Benning, Ga. Consequently, this circular could only be partially effective, and it is to be regretted that an early systematic approach could not have been provided throughout the War Department. There seems little doubt, however, that this effort, even though late, was one of the signal achievements of the Surgeon General's Office in the field of psychiatry.

TRAINING FILMS

During the first 2 years of the war, the limitation of manpower in the Neuropsychiatry Consultants Division, SGO, and the pressure of other immediate tasks resulted in inadequate attention being given to the devel-

[6] Army Service Forces Circular No. 215, 11 July 1944.

opment of training films. No one doubted their great value but the expense and the time required for the development of such, plus the difficulties in arranging for such films to be made, led to the postponement of any active planning in this direction. The result was that four of the first films to be made were initiated and carried through either in the theaters or in the service commands. Two additional films were adopted from the Navy and still two others were adopted from British films.

The experience with these films, however, was so satisfactory that a general program was outlined, setting forth the specific needs for various films, and a military psychiatrist, Maj. George S. Goldman, MC, was placed on full-time duty to develop this program.

The division had cooperated with many other officers in the planning and production of psychiatric films and reviewed films produced by other agencies, making recommendations as to their adoption and utilization. Later, it had instituted and collaborated in the production by the Information and Education Division, ASF, of an educational film dealing with the reactions of fear, regimentation, deprivation, discipline, resentment, emotions, and bodily changes.

The first step in the development of an adequate psychiatric film library was to survey the total needs for psychiatric films and to draw up a list of all desirable films. The purpose and the audience for which each was intended and a brief summary of their content was given in the preliminary list and against this was checked the films already adopted by the Army, those which could be adopted, and those in production or already proposed. While it would have been desirable that one film be planned for one specific purpose and a specific audience, for reasons of practicality it was necessary that each film perform as many functions and reach as wide an audience as possible.

At the time Major Goldman undertook this program, a number of films had been adopted and were being distributed.[7] Others were later developed and in the process of production.[8]

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[7] PMF (Professional Medical Film) 5011, "Psychiatry for the General Medical Officer," originally developed by the British and redeveloped by the U.S. Army, 1945. FB (Film Bulletin) 184, "Psychiatric Procedures in the Combat Area," developed in the Mediterranean theater by Lt. Col. Frederick R. Hanson, MC, Maj. Calvin S. Drayer, MC, and Maj. Stephen W. Ranson, MC. TF (Training Film) 8–1402, "Introduction to Combat Fatigue," developed by the Navy, 1944. PMF 5012, "Combat Exhaustion," developed in the 312th Station Hospital in England by Col. Lloyd J. Thompson, MC, Col. Ernest H. Parsons, MC, and Maj. Howard D. Fabing, MC, 1945. TF 8–1428, "Care of the Sick and Injured—The NP Patient," developed by the Navy, Lt. Comdr. Howard P. Rome, 1945. TF 8–2090, "Ward Care of Psychotic Patients," developed in the Ninth Service Command by Col. Lauren H. Smith, MC, and Col. Olin B. Chamberlain, MC, 1945. Special Film, "Hypnosis—Okinawa," developed by Lt. Col. M. Ralph Kaufman, MC, and Maj. Lindsay E. Beaton, MC. Miscellaneous Film 1133, "The New Lot," developed by the British. PMF 5019, "Let There Be Light," developed at Mason General Hospital with actual patients and personnel, 1946—a famous actor, Walter Huston, was the narrator; his son, Maj. John Huston, was director and producer. Later, in 1948, this film was remade with professional actors and retitled "Shades of Gray," PMF 5047. "Your Job and the Psychiatric Patient," a three-part film, was not completed until after V–J Day and then released in 1947—Part I: The Psychiatric Patient; Part II: How the Patient May Affect the Attendant; Part III: The Attendants Help the Patients.

[8] Department of the Army Special Regulations No. 110–1–1, Index of Army Motion Pictures and Film Strips, 5 Jan. 1950, pp. 111–112.

CHAPTER V

The Consultant System

William C. Menninger, M.D., Malcolm J. Farrell, M.D., and *Henry W. Brosin, M.D.*

THE NEED FOR CONSULTANTS

There was mutual agreement among Regular, Reserve, and Army of the United States medical officers in World War II that the development of the consultant system in the Medical Department was one of the most important progressive steps made during the war. Certainly, it was largely responsible for the high professional standards of practice and treatment that existed in every specialty of medicine throughout the Army, both in the Zone of Interior as well as in the theaters of operations. Credit for the vision and initiation of the plan for consultants for service commands belongs to the Director, Medical Consultants Division, Brig. Gen. Hugh J. Morgan, and to the Director, Surgical Consultants Division, Brig. Gen. Fred W. Rankin, both in the Surgeon General's Office.

From the beginning of the plan, neuropsychiatry was recognized as being responsible for a sufficiently large problem to justify a consultant in this specialty, paralleling the consultant in internal medicine and the consultant in surgery. Consequently, throughout the Army Service Forces, in which all medical installations were under the jurisdiction of The Surgeon General, the professional triad of consultants always included the neuropsychiatrist. Later, in several service commands, the orthopedic surgeon was included, and in certain theaters, additional consultants in other fields were appointed. The Army Ground Forces and the Army Air Forces, whose medical activities were not directly under The Surgeon General, in some degree also adopted the consultant system, including the internist, the surgeon, and the neuropsychiatrist in the combat armies, and qualified men in certain specialties attached to the Air Surgeon's Office.

The consultant system, in part, was necessitated because of the size, the geographic distribution, and the organization of the Army. Obviously, it was impossible for a single office, even when at its greatest strength, to supervise and coordinate the professional standards of medicine throughout the Army in its many ramifications. Following the pattern of World War I, the oversea theaters, in most instances, effected plans for and the appointment of consultants before the professional consultant system was organized in the Zone of Interior; the latter plan was entirely new in World War II.

DEVELOPMENT IN ZONE OF INTERIOR

The plan, as envisioned, called for experienced specialists in each of the three major fields to be specially appointed and commissioned for the purpose of supervising and standardizing the professional work done in all medical installations. It was recognized from the outset that such men in the Regular Army, who might be qualified for such positions, would be assigned to full-time administrative positions. It was intended that professional consultants would have a minimum of administrative responsibility. The duties of each would be primarily professional, as a consultant in his specialty, traveling from one hospital to another, in nearly a continuous fashion. Plans were initiated, early in 1942, to appoint this group of well-qualified and recognized physicians for the purpose of assuming professional supervision over the practice of the three major specialties in service commands.

A letter[1] requesting approval and appointment of such consultants to service commands was submitted by The Surgeon General, on 28 May 1942. In this letter, The Surgeon General mentioned that, at the time, there were 209 station hospitals and 71,459 hospital beds in the 9 corps areas (later designated as service commands) of the United States and that the bed capacity would shortly increase to 158,352. He recommended that 27 such specialists (psychiatrist, internist, and surgeon for each corps area) be appointed and commissioned in the grade of lieutenant colonel. He also asked for an increase in personnel allotments to permit such additions.[2]

In reply, as a first indorsement, dated 1 June 1942, the Director of Military Personnel for the Commanding General, SOS (Services of Supply, later ASF (Army Service Forces)), stated there was no objection to the assignment of these medical officers to corps areas (service commands) but denied an increase in allotment because the number of medical officers on duty was well below the number authorized by the original allotment.

Apparently anticipating some resistance on the part of the corps area commanders to the assignment of three medical officers to their staffs, another letter[3] by The Surgeon General requested that an official directive be issued, incorporating the duties and responsibilities of these consultants. No action was taken on the recommendations in this letter, but reference was made to existing directives, especially WD (War Department) Circular No. 59, issued on 2 March 1942, which had established a basis of responsibility and authority for such technical medical activities. The

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[1] Letter, The Surgeon General, to The Commanding General, Services of Supply, 28 May 1942, subject: Coordination of Medical Service (Professional) in Corps Area Installations.

[2] It should be noted that many service commands utilized military or civilian psychiatrists as informal consultants who visited various posts and stations, as requested, and reported to the service command surgeons.—A. J. G.

[3] Letter, The Surgeon General, to The Commanding General, Services of Supply, 23 June 1942, subject: Coordination and Supervision of Medical Service in Station Hospitals, with 1st indorsement thereto, Headquarters, Services of Supply, to The Surgeon General, 14 July 1942.

Surgeon General was also told to "report further any difficulties beyond his authority to adjust."

Thus, having obtained approval for the use of consultants, The Surgeon General, on 28 July 1942, sent identical letters to the commanding generals of all service commands, and also to the Commanding General of the AAF (Army Air Forces), informing them of the action taken and referring specifically to the pertinent correspondence emanating from the offices concerned. The main body of this letter, which follows, is quoted because it actually established the policy governing the activities of service command consultants.

* * * * * * *

2. In order to coordinate and supervise the medical service of Army hospitals in accordance with the above authorization, qualified consultants in medicine, surgery, and neuropsychiatry will be assigned in the early future to the staffs of the Fourth, Seventh, Eighth, and Ninth Service Commands. Professional consultants will be assigned to the remaining service commands when, because of the expansion of hospital facilities, their need is apparent or when, in the opinion of the commander of the service command concerned, the needs of the service command warrant the assignment of consultants in one or more specialties.

3. To promote uniformity in supervisory functions, the various fields of medicine and surgery will be assigned to consultants as follows:

Medicine. All medical specialties (except neuropsychiatry), venereal disease, dermatology, dietetics, and clinical pathology.

Surgery. All surgical specialties (including urology), ophthalmology, otorhinolaryngology, radiology, and physical therapy.

Neuropsychiatry. Neurology, psychiatry, and war neuroses.

4. Although consultants will interest themselves especially in the fields designated, it will be deemed appropriate for the consultant in any field to cover all the professional services of a hospital in his inspection when so directed by the commander of the service command.

5. These officers will serve in an inspectoral and consultative capacity, and their activities will cover all fixed Medical Department installations for the care of the sick and injured within the geographical limits of their respective service commands, except Walter Reed General Hospital and the General Dispensary, U.S. Army, Washington, D. C., which for this purpose will be directly under The Surgeon General. Their duties will include the coordination of professional practice by local discussions with hospital staffs of professional subjects in general and such special problems as may present themselves; appraisal of therapeutic and diagnostic procedures and agents, and miscellaneous other duties which may come within their respective specialized professional fields.

6. Each consultant will render a written report concerning his activities at each facility visited. Original reports will be forwarded to the commander of the service command except in the case of Air Corps stations, concerning which original reports will be forwarded directly to the Commanding General, Army Air Forces (Attention: The Air Surgeon), a duplicate in such cases being forwarded to the commander of the service command. In each case a duplicate report will be furnished the commanding officer of the station concerned and another forwarded directly to The Surgeon General.

On 22 October 1942, Brig. Gen. (later Maj. Gen.) David N. W. Grant, the Air Surgeon, notified The Surgeon General: "It is the desire of this office that the medical consultants in all Service Command Areas be made

available to Air Force Station." The Air Surgeon further stated that a copy of The Surgeon General's letter, just quoted, had been sent to all Army Air Forces Commands and Air Forces.

THE ASSIGNMENT OF PSYCHIATRIC CONSULTANTS

Zone of Interior

The assignment of the service command psychiatric consultants was left very largely to the Chief Consultant in Neuropsychiatry, in the Surgeon General's Office, on the advice of and approval by the Chief of Professional Service, Brig. Gen. Charles C. Hillman, and the approval of The Surgeon General, Maj. Gen. James C. Magee, and later, Maj. Gen. Norman T. Kirk. Despite the influence of the Surgeon General's Office, the appointment and the assignment of these specialists encountered certain difficulties. The job necessarily called for a man of demonstrated professional ability and with a reputation in his field which would command respect. There were relatively few such individuals available, and many who would have, theoretically, been eligible, were occupying positions in civilian life in which they were classified by the Procurement and Assignment Service, of the War Manpower Commission, as "essential." It should be stated that many of those in this essential category disregarded it and came into the Army. When the consultant system began in 1942, despite the fact that the Army was growing rapidly, there were some of the smaller commands which hardly justified the full time of so high a caliber of professional man. Because the whole consultant system was new, there was some resistance, and in one instance, there was open hostility to the appointment of a neuropsychiatric consultant.

Despite these difficulties, the first neuropsychiatric consultant in the service commands, Lt. Col. (later Col.) Franklin G. Ebaugh, MC, was appointed on 27 August 1942, to the Eighth Service Command, and Lt. Col. (later Brig. Gen.) William C. Menninger, MC, was appointed on 25 November 1942, to the Fourth Service Command; five more neuropsychiatric consultants were appointed to the various service commands in 1943. The neuropsychiatric consultant to the Fifth Service Command, the last vacancy to be filled, was appointed on 22 August 1944. Neuropsychiatric service command consultants were as follows:

First Service Command:

Maj. (later Lt. Col.) Wilfred Bloomberg, MC, 29 June 1943–21 August 1945.
Col. Lloyd J. Thompson, MC, 4 September–21 December 1945.
Lt. Col. Wilfred Bloomberg, MC, 17 December 1945–12 July 1946.

Second Service Command:

Lt. Col. (later Col.) Douglas A. Thom, MC, 25 March 1943–31 January 1946.

Third Service Command:

Lt. Col. (later Col.) Henry W. Brosin, MC, 15 April 1944–21 December 1945.

Fourth Service Command:
Lt. Col. William C. Menninger, MC, 25 November 1942–10 December 1943.
Lt. Col. Paul L. Schroeder, MC (fig. 15), 13 March 1944–31 October 1945.
Fifth Service Command:
Maj. William H. Dunn, MC, 22 August 1944–15 February 1946.
Sixth Service Command:
Col. William J. Bleckwenn, MC, 5 August 1944–12 December 1945.
Seventh Service Command:
Maj. Garland C. Pace, MC, 1 January–25 September 1943.
Lt. Col. Clarke H. Barnacle, MC, 10 December 1943–10 August 1945.
Lt. Col. John H. Greist, MC, 12 June 1945–15 February 1946.
Eighth Service Command:
Lt. Col. (later Col.) Franklin G. Ebaugh, MC, 27 August 1942–28 May 1945.
Lt. Col. Perry C. Talkington, MC, 20 July–20 September 1945.
Ninth Service Command:
Lt. Col. (later Col.) Lauren H. Smith, MC (fig. 16), 16 October 1943–15 December 1945.

FIGURE 15.—Lt. Col. Paul L. Schroeder, MC, Neuropsychiatric Consultant, Fourth Service Command.

Oversea Theaters

During World War II, consultants in oversea theaters were valuable, even necessary, and consequently, even before the consultant system was placed into effect in the Zone of Interior, plans were underway and appointments made for neuropsychiatric consultants in the European theater and

FIGURE 16.—Col. Lauren H. Smith, MC, Neuropsychiatric Consultant, Ninth Service Command.

the Southwest Pacific Area. Lt. Col. (later Col.) S. Alan Challman, MC (fig. 17), was appointed and sent to the Southwest Pacific on 25 May 1942, and on 12 August 1942, Lt. Col. (later Col.) Lloyd J. Thompson, MC, was dispatched to the European theater. After the Mediterranean theater became active, Capt. (later Lt. Col.) Frederick R. Hanson, MC, was appointed for that area. In the Pacific Ocean Areas, Lt. Col. (later Col.) M. Ralph Kaufman, MC, was assigned as consultant in the South Pacific Base Command. A neuropsychiatric consultant, Maj. (later Lt. Col.) John R. S. Mays, MC, was sent to the Burma-India theater in January 1945, and in this same year, an acting neuropsychiatric consultant, Maj. John M. Flumerfelt, MC, functioned in the Middle East theater with his headquarters in Cairo, Egypt. With the exception of the Pacific Ocean Base Command and the Alaska Base Command, all oversea theaters with large troop strength were provided with a neuropsychiatric consultant, as follows:

Southwest Pacific Area:

Lt. Col. (later Col.) S. Alan Challman, MC, 25 May 1942–11 June 1945.
Col. Franklin G. Ebaugh, MC, 12 June–1 December 1945.
Lt. Col. Clarke H. Barnacle, MC, 10 October 1945–23 January 1946.

FIGURE 17.—Col. S. Alan Challman, MC, Neuropsychiatric Consultant, Southwest Pacific Area.

Southwest Pacific Area—Continued
Maj. Ivan C. Berlien, MC, 26 September 1945–19 January 1946.
Lt. Col. William H. Everts, MC, 7 August–21 November 1945.
European theater:
Lt. Col. (later Col.) Lloyd J. Thompson, MC, 12 August 1942–12 August 1945.
Lt. Col. Joseph S. Skobba, MC, 14 August–22 December 1945.
Mediterranean theater:
Capt. (later Lt. Col.) Frederick R. Hanson, MC, 22 February 1943–July 1945.
South Pacific Area:
Lt. Col. (later Col.) M. Ralph Kaufman, MC, 26 October 1943–20 August 1944.
Lt. Col. (later Col.) Edward G. Billings, MC, 2 November 1943–7 June 1945.
Pacific Ocean Areas:
Lt. Col. (later Col.) M. Ralph Kaufman, MC, 30 August 1944–1 June 1945.
China-Burma-India theater:
Maj. (later Lt. Col.) John R. S. Mays, MC, 26 January–31 October 1945.
Middle East theater:
Maj. John M. Flumerfelt, MC, 29 December 1944–11 July 1945.

In contrast to the service command consultant, however, the theater consultant functioned entirely under the jurisdiction of the theater surgeon, who was largely independent from the Surgeon General's Office. Consequently, the work of the theater consultant varied widely, depending on the opportunities he was given. In some instances, he was entirely free and unhampered; in others, he was greatly handicapped by regulations

within the theater. Because theater medical organizations were so independent of War Department control, the theater consultant had far more "staff work" (preparation, documentation, and implementation of policy) to accomplish than did the consultant in the service command. In the latter, the consultant was largely concerned with professional work and with visits to medical installations.

Combat armies.—The combat armies also were included in the total program for professional consultants—the First U.S. Army appointed its neuropsychiatric consultant on 31 December 1943 and the Third U.S. Army followed soon thereafter, on 23 January 1944. During the course of 1944, all but the Sixth U.S. Army availed themselves of the services of a neuropsychiatric consultant.[4] The surgeon of the Sixth U.S. Army steadfastly refused to accept the services of such a consultant until June 1945.

FIGURE 18.—Lt. Col. Joseph S. Skobba, Neuropsychiatric Consultant, Fourth and Fifteenth U.S. Armies.

[4] The actual appointment of a neuropsychiatric consultant to the Fifth U.S. Army was delayed because the tables of organization vacancy had originally been allocated to another section of the Fifth U.S. Army headquarters. Capt. (later Lt. Col.) Calvin S. Drayer began his services as consultant to the Fifth U.S. Army informally as early as December 1943. On 21 July 1944, he was placed on temporary duty in this office, and it was not until February 1945 that it was possible for him to actually be assigned to this position.

Neuropsychiatric consultants in the armies and their periods of assignment were as follows:

First U.S. Army:
Lt. Col. (later Col.) William G. Srodes, MC, 27 December 1943–14 December 1945.
Third U.S. Army:
Lt. Col. Perry C. Talkington, MC, 23 January 1944–1 July 1945.
Fourth U.S. Army:
Lt. Col. Joseph S. Skobba, MC (fig. 18), 20 August–28 September 1944.
Maj. (later Lt. Col.) Manfred S. Guttmacher, MC, 6 August–2 November 1945.
Fifth U.S. Army:
Maj. (later Lt. Col.) Calvin S. Drayer, MC (fig. 19), 21 July 1944–27 August 1945.
Sixth U.S. Army:
Lt. Col. (later Col.) M. Ralph Kaufman, MC, 1 June–28 September 1945.
Seventh U.S. Army:
Maj. Alfred O. Ludwig, MC, 21 July 1944–10 July 1945.
Eighth U.S. Army:
Maj. (later Lt. Col.) Josiah T. Showalter, MC, 17 June 1944–1 October 1945.
Ninth U.S. Army:
Lt. Col. (later Col.) Roscoe W. Cavell, MC, 20 May 1944–19 September 1945.
Tenth U.S. Army:
Lt. Col. Oscar B. Markey, MC, 10 August 1944–15 October 1945.

FIGURE 19.—Lt. Col. Calvin S. Drayer, MC, Neuropsychiatric Consultant, Fifth U.S. Army.

Fifteenth U.S. Army:
Lt. Col. Joseph S. Skobba, MC, 28 September 1944–12 August 1945.

One of the examples of the uphill struggle of neuropsychiatry in the Army is exemplified in the regulations and the table of organization laid down for the professional consultants in the field armies. In this table of organization, the neuropsychiatric consultant was listed as the "assistant medical consultant" with the rank of lieutenant colonel, although the consultants in medicine and surgery were rated as colonel. The Neuropsychiatry Consultants Division, SGO (Surgeon General's Office), over a period of many months attempted to have these officers assigned and titled as "Consultant in Neuropsychiatry" with the same rank as the other two specialties. Not until nearly the end of the war was concurrence obtained for this change.

GENERAL FUNCTIONS OF THE CONSULTANT

A remarkable feature about the consultant system was the fact that, despite its importance and its prominence in the function of the Medical Department, it was not until almost a year after V–E Day that a circular was issued directing the functions and the responsibilities of the professional consultant. It was not until WD Circular No. 12 was issued, on 12 January 1946, that The Surgeon General was specifically authorized to appoint such consultants, although the details of their responsibilities were never printed in any official Army literature. Despite absence of formalization, the consultant system worked so effectively on the basis of the experience in the practice of clinical medicine, surgery, and neuropsychiatry that specific instructions were not essential. A training program was developed for neuropsychiatric consultants whereby each new consultant coming into the service served with one of the functioning consultants for a month prior to assignment in a service command. Undoubtedly, the neuropsychiatric consultant was regarded initially with more skepticism and was accepted less enthusiastically than was the case with the internist or surgeon; on the other hand, without a single exception in every service command, he succeeded in completely dispelling this skepticism and winning full acceptance.

The functions of the neuropsychiatric and other consultants were officially listed in WD Circular No. 101, issued on 4 April 1946:

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2. As representatives of The Surgeon General, the professional consultants are concerned essentially with the maintenance of the highest standards of medical practice. It is their function to evaluate, promote, and improve further the quality of medical care * * * by every possible means, and to advise in the formulation of the professional policies of The Surgeon General and to aid in their implementation. The proper performance of these functions necessarily involves an appraisal of all factors concerned with * * * the professional care of patients, including particularly the organization and program of professional services in medical installations, the quality,

numbers, distribution, and assignment of specially qualified professional personnel, the diagnostic facilities including roentgenologic and laboratory procedures, the availability and suitability of equipment and supplies for professional needs, and the nursing care, dietary provisions, recreational and reconditioning facilities, and other ancillary services which are essential to the welfare and morale of patients. The professional consultants exercise their functions by assisting and advising The Surgeon General, the surgeons of major forces and commands, * * * on all matters pertaining to professional practice * * * by providing advice on professional subjects in general and on newer developments in * * * diagnosis, treatment, and technical procedures, by stimulating interest in professional problems and aiding in their investigation, and by encouraging * * * educational programs such as conferences, ward rounds, and journal clubs * * *. The execution of these functions involves periodic visits to medical installations and other types of units concerned with the medical care of military personnel. The functions of professional consultants vary somewhat according to their assignments.

As one of the functions just listed, the service command consultants and, in a lesser degree the theater consultants, acted as a liaison between the Surgeon General's Office and the field. It was primarily through their reports of medical installations that the Surgeon General's Office could keep informed as to problems in the field, and permission was gained early to have free exchange of personal communications between consultants and the Surgeon General's Office. Various members of the Neuropsychiatry Consultants Division, SGO, frequently accompanied the consultant on his visits to medical facilities in his command. This practice also applied to the theaters of operations.

At the beginning of the war before the true magnitude of the war effort became apparent, some surgeons and post commanders regarded psychiatric consultants as intrusive upon their command responsibility because they had been trained to do all jobs themselves.[5] This commendable goal was difficult to accomplish with the influx of inexperienced and young officers so that most of them welcomed the manifest help given them, just as some division commanders could accept division psychiatrists without loss of prestige. Initially, the stereotype that psychiatrists were suspect themselves because they were apt to be deviant or queer was a handicap. Also troublesome was the belief that psychiatrists dealt only with psychotics, until the value of psychiatry in other areas was demonstrated. It is gratifying that, with very few exceptions, most psychiatrists won acceptance on their own merits with their nonmedical officers. Another prejudice which needed correction was the bias against educational activities. A medical officer on coming into the Army, according to this view, was fully equipped to discharge whatever duties he was assigned within his rank and military occupational specialty, and efforts to hold case conferences and journal clubs were viewed as a waste of time and a means of evading duty. The support of the Surgeon General's Office and service command authority for better education in professional matters was of tremendous help in improving patient care and officer morale.

[5] The remainder of this chapter refers mainly to the work of the service command consultant; however, oversea consultants performed in a similar manner.—A. J. G.

Staff Activities

The consultant in each service command was expected to be a staff officer and assistant to the service command surgeon. As a staff officer in a line organization, he found communications poor regarding some professional matters and very little opportunity for active control, except as the surgeon and the commanding general of the service command agreed to implement an action at the posts and hospitals in the service command. Because the policies and tactical problems were quite different in the nine service commands and the personality of each commanding general and his staff and of each surgeon and his staff varied widely, there is little possibility of accurately summarizing the job specifications and the workload of each of the service command consultants. However, some approximation was possible, and the duties of the psychiatrists in these staff positions have been described in detail by Glass and his associates.[6]

Professional Activities

By means of the staff advisory activities in headquarters and by direct evaluation, discussion, and stimulation at local stations, psychiatric consultants were in a good position to help medical officers in all installations solve problems of diagnosis, recordkeeping, preparation for boards, technical treatment procedures, and disposition. Uniform interpretation of the policies and directives of the Surgeon General's Office and service command headquarters to medical officers was an important means of making possible more effective work. As a senior with wide experience in civilian and military installations, the consultant could often offer useful suggestions. At the very least, he could offer to the local medical officers and his superiors reassurance that they were doing the best that could be done under the circumstances. In some troublesome cases, he could resolve differences of opinion and seek new solutions from the local command or the service command. Occasionally, he could obtain valuable help in interpretation and operation from the Office of The Surgeon General. At all times, the service command psychiatrist could expect a sympathetic ear from the Neuropsychiatric Section of the Professional Service Division, SGO, which was highly important to all concerned regarding decisions which had to be made when overall Army policy was in doubt.

Field Visits

The psychiatric consultant was especially welcomed in the field when new directives on treatment methods, on the use of psychologists, social workers, and other workers, and on disposition criteria and methods were

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[6] Glass, A. J., Artiss, K. L., Gibbs, J. J., and Sweeney, V. C.: The Current Status of Army Psychiatry. Am. J. Psychiat. 117: 673–683, February 1961.

issued and studied. Since he had direct access for information to the surgeon and the Professional Service Division, he could help field personnel in their interpretations and planning. He could also assist the service command surgeon in interpreting new directives on professional practice and technical procedures.

Most consultants spent from 50 to 70 percent of their time in visiting installations. The temptation to remain in service command headquarters to work at the ever-present paperwork, that of answering letters from many sources including medical officers in the service command, of writing up reports of the last trip, and of keeping in touch with new developments at the source of power, was great at times. However, most consultants realized that their work in field installations was probably their major contribution, no matter how much influence could be exercised at headquarters.

It was the personal satisfactions received from dealing with the overburdened workers in the field which made the visits of consultants seem worthwhile. After the initial period of acquaintance with consultants' visits during which time post personnel, as well as medical officers, learned that the consultant came to help professionally, and not as an inspector or as an officer to exercise power, the overwhelming majority of Army personnel accepted him for what he was, a physician-consultant, and welcomed him with open arms. There was always much work to do, patients to discuss, and local personnel as well as policy questions to review. Some post surgeons and hospital commanders made much more use of consultants than others, so that the consultant had to budget his time carefully to get to the patients' care level at all. In other installations, the consultant was required merely to make a formal appearance to the post surgeon or the hospital commander and then could spend all of his time with the medical team. Because of his association with them, the consultant, although he had no command function, could assist the surgeon in implementing War Department policies.

Reports

Consultants were required in most cases, particularly during visits in the early war years or where visits were made infrequently, to write reports of their visits to installations. The original report was sent to the surgeon of the service command, one copy was sent to the commanding officer of the station concerned, and another was forwarded directly to The Surgeon General.

These reports were valuable in several ways. They constituted, in many cases, the only record of the number of persons, of their qualifications, and of their assignments on post to both the surgeon of the service command and The Surgeon General. When consultants visited posts, they had the time and the opportunity to evaluate the abilities of medical personnel and were able to advise the local commanding officer and the sur-

geon about promotions, reassignments, rotation, or similar questions when this advice was requested. Malassignment was quickly detected and usually corrected, if the consultant pointed out inequities. Efficiency in organization and imaginative use of the limited personnel available were encouraged when officers were indecisive. Many consultants did extremely well in recruiting personnel and in improvising facilities for patient care, rehabilitation, occupational therapy, and recreation.

Correction of Local Problems

Occasionally, particularly in the early part of the war, the consultant could assist the medical officer in obtaining better facilities for housing patients, occupational therapy, reconditioning, rehabilitation, and recreation. Some of the consultants who came in early in the war (1943) wrote that a large part of their work at that time was taken up with obtaining reasonably good physical quarters and equipment, whereas later in the war, their work was related to more specific professional problems. At all times, he could aid in helping the neuropsychiatric service or section get more personnel and facilities for the ancillary services. In some service commands, this part of the consultants' survey work was extremely important because the surgeon made judgments based upon this information. It should be noted, however, that the written reports were usually written in neutral language regarding the excellences and deficiencies of a program. The more intimate evaluations were given verbally and with discretion. In this way, highly motivated and well-trained officers with superior abilities could be recognized and rewarded. Differences of opinion on professional matters could either be reconciled or be adjusted so that the climate improved.

The Consultant as a Teacher

There is an old Army adage that every officer is in some way a teacher, and it is true for most officers who deal with troops that they spend much time, energy, and thought about training. This was certainly true for the psychiatric consultant who had to keep alert at all times to the ever-changing regulations, to anticipate changes, to keep abreast of military and civilian progress in diagnosis and treatment methods so that he could discuss them intelligently, and to keep in touch with clinical work sufficiently to be able to help with difficult diagnostic problems, particularly in the neurological or medical fields.

The consultant was expected to be lively and entertaining, as well as informative, because this stimulated interest in both military and professional work. One of the more rewarding aspects of the local visits were the purely educational programs, clinical case seminars, or case conferences, ward rounds, and journal clubs. Often, especially when the visits of the

consultant were infrequent, he was asked to give lectures on some scientific subject in which he was known to have an interest. The consultant was often able to convince a chief of a neuropsychiatric service, who had only one or two assistants, that an educational program which included nurses, social workers, psychologists, occupational and recreational workers, nurse therapists or other specialists, and psychiatric aids was indeed worthwhile. It was demonstrated repeatedly that, if the medical personnel could retain a strong sense of their professional identity, they were very much happier with themselves and with their work. Many of those unfortunate physicians who, at the outset of their Army experience, believed that they could not practice without a huge laboratory with much special equipment or who practiced medicine by means of rigid schedules learned to their surprise that they were delighted with practicing more of the art of medicine with less dependence upon laboratory procedures. Some gained insight about their use of mechanical, radiological, and chemical methods of "treatment" as a defense against dealing with the personal problems of the patient. In some of the service commands, the consultants in medicine and surgery were extremely helpful in this regard and were highly skillful and successful in persuading medical officers to practice a better grade of comprehensive medicine.[7]

Informal programs for on-the-job training of nurses, social workers, psychologists, psychiatric aids, and other specialists were not uncommon in many of the larger post hospitals early in the war because the pressures on medical officers were great and they responded with ingenuity. Later, these informal programs were given much better status and recognition by commanding officers of installations. When reconditioning techniques were being developed, the training of appropriate personnel was officially approved. That the consultant was often able to obtain judgments, data, attitudes, and decisions from the service command surgeon and the Neuropsychiatry Branch of the Professional Service Division enabled him to be a teacher of military policy and directives in these new projects.

The consultant was also a teacher in the sense that he initiated when required, or encouraged when desirable, the use of social workers, psychologists, occupational and recreational therapists, and other useful members of the psychiatric team. Because many of the psychiatrists were young and inexperienced, or came from State hospitals where they were not familiar with the use of ancillary personnel, they had to be helped in the initial stages of building up a team. Most of them learned rapidly and became at ease with this method of functioning instead of the more classic State hospital or private practice techniques.

The introduction of the officers from the Medical Administrative Corps into psychiatric units to perform nonmedical duties was occasionally a difficult problem until the persons concerned learned how they could help

[7] Bauer, W., and Brosin, H. W.: The Importance of Preventive Psychiatry in Psychosomatic Medicine. [Unpublished manuscript.]

each other to mutual advantage. Procurement and advantageous use of these and other paramedical personnel was often a task at which the consultant could assist the service command surgeon and commanding officers of installations.

Morale Function

One of the intangible but most valuable functions of the service command consultant was to improve the morale of his colleagues in the field. During the often trying days when personnel was inadequate in quality and quantity and the management of patients was something less than satisfactory because of poor leadership, poor directives, and lack of facilities, the visit of a senior professional colleague from service command headquarters was a welcome change. The consultant brought status and prestige to the clinician who often felt neglected or forgotten. The clinician could express his frustrations and dissatisfactions to the consultant with greater freedom than he could to his own commanding officer. Pressing professional questions could be reviewed with mutual interest and profit. A renewed sense of a professional identity was gained in addition to the military model to which most men were overwhelmingly and scrupulously loyal even though discouraged about their own activities. The consultant could be used as a counselor on delicate personnel problems before more public action was requested.

After service command surgeons and commanding officers of installations learned that they could trust the consultants' discretion, judgment, and common sense about the realities of Army life, they often used them as advisers or informal messengers regarding evaluation and assignment of personnel or for the correction of difficulties. The never-ending series of questions on administrative problems was a constant source of conversation. For many medical officers, the consultant was a significant figure because he was able to convey messages to service command headquarters and to the Professional Service Division, SGO, thus giving them some sense of belonging to a large organization in contrast to being isolated in a tiny ward or clinic in a remote camp. Since many of the men in local installations had exceptional ideas and ability, they did help initiate and encourage new or revised practices which received publicity via the consultants. Such recognition did much to lift the painful anonymity of the isolated post. The consultant brought news, both professional and personal, as well as administrative, regarding friends in other parts of the world which also relieved the monotony and the sense of being out of touch. During the earlier days of the war when directives were few and often ambiguous, the consultant could bring in copies of the War Department or Army Service Forces directives as reissued by the service command. They could also distribute reprints on military subjects such as those provided by the Josiah Macy, Jr.

Foundation,[8] or other pertinent references from the American or British literature.

Summary

In summary, all consultants uniformly reported from their firsthand experience that, although the background and training of the psychiatrists in the Zone of Interior varied widely and though a few were not fitted for military life, with few exceptions, they were exceptionally "conscientious, loyal, hardworking, and cooperative men who had a genuine concern for the patient's welfare and a high degree of therapeutic intent. They were exposed to much frustration, but they maintained their professional attitudes and sense of responsibility in an admirable fashion." [9]

The activities of the medical and psychiatric units of the service commands are described in separate chapters of this volume so no attempt will be made to summarize them here.

PERSONNEL PROBLEMS IN THE SERVICE COMMAND

Inadequate Quantity and Quality of Personnel

It is not feasible nor necessary to further devote additional space to the influence wielded by the commanding generals of service commands or the service command surgeons upon the psychiatric care of patients, by means of directives, instructions, or more subtle pressures, during the trying days of mobilization and the pressures which came with the shocking loss of manpower during 1942–43. An earlier chapter (pp. 41–51) amply outlines the broad picture of the manpower problem together with the policies and operations which affected the mental health of troops and care of psychiatric patients. The pertinent regulations are reproduced in appendix B.

The leadership in the War Department was under the guidance of able and well-intentioned men who had the difficult burden of carrying an unprecedented load of large tasks for which ground rules had to be developed as they went along. They had to satisfy the strenuous demands of their vigorous superiors, often with unclear, inadequate, and even unrealistic directives within a short time, often too short, considering local handicaps. These tasks had to be performed with men in the field who were untrained for their missions for the most part, and many were simply incompetent. This unpleasant fact which is unlikely to receive much space in an official history was another cause of impaired morale since these incompetents,

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[8] Literature was made available by the Josiah Macy, Jr. Foundation, N.Y., distributed through the National Committee for Mental Hygiene.

[9] Dunn, William H.: History of Neuropsychiatric Activities of the Fifth Service Command, 1 January 1941 to 15 August 1945. [Official record.]

under stress of wartime demands, reflected their unhappiness in all directions and used up the energy of their capable neighbors to help themselves avoid prison, psychosis, or some less drastic, but no less destructive, chronic adaptation. As stated by Millett—

> The service commands tended to be the dumping ground for all the field grade officers whom the Army Ground Forces found unsatisfactory. This produced a difficult personnel situation and helped to explain why some of the technical services and perhaps even the Army Air Forces distrusted the service commands. General Somervell and the commanders of the service commands could only make the best of a troublesome situation.[10]

Millett's statement regarding field officers appeared also to be true for other ranks down to private in all branches and lent a special flavor to the work done by the service commands and the Medical Department. The Doolittle Board pointed out the shortsightedness and the wastefulness of the methods of assignment and probation of officers. It also recognized the tragedy of keeping noneffective officers in the service, especially in field grades or higher, because disposition methods were extremely cumbersome. Reclassification in a genuine sense was almost impossible, and grossly incompetent officers were merely sent from job to job or post to post, sometimes with greater responsibilities while the health of all concerned suffered.[11]

Relationship to Psychiatry

It must be remembered that neither line officers nor medical officers, with few exceptions, understood or had any experience with modern psychiatry with its emphasis upon psychotherapy and activation of patients by numerous methods, including chemical, electrical, or mechanical devices. The Regular line and medical officers also had no indoctrination in field psychiatry which had proved useful in the prevention of neuropsychiatric disorders and treatment of soldiers under stress in training overseas. The civilian psychiatrists who came into the Army in 1941–42 for the greatest part had no experience with either the Army or in dealing with large groups as such. Many of those who did come in were relatively young and were unable to gain the attention of their superiors even if they had good ideas. Many of the older and more experienced men were highly biased in favor of a private practice schedule where they expected to see relatively few patients for private interviews each day. They were sometimes not easily transposed to a busy dispensary, mental hygiene clinic, or a crowded ward, although most of them were remarkably good natured while they gained a new identity as Army medical officers. Those medical officers who

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[10] Millett, John D.: The Organization and Role of the Army Service Forces. United States Army in World War II. The Army Service Forces. Washington: U.S. Government Printing Office, 1956, p. 371.

[11] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 527.

had served in large institutions were not accustomed to the concept of being responsible for the health of a large group of men, and they had to learn the new medium of preventive psychiatry for large populations. Incidentally, contrary to the popular jokes about the mysterious jargon of psychoanalysis, their presumed obsession with sex and the couch, most psychoanalysts in the Army did outstanding work and earned the high regard of their colleagues and superior officers. If one remembers that there were fewer than 500 analysts in the United States in 1940 and that most of them were more than 45 years old and often in responsible positions, their record for military performance is little short of remarkable.

An unforeseen result of the influence of psychoanalytic teaching with its emphasis upon psychotherapy was that there was an unprecedented demand for psychoanalytic training by the young medical officers upon their discharge from the Army. This overload continued well into the 1950's. While it is not easy to know all the reasons for this phenomenon, one can name two factors; namely, the leadership of Brig. Gen. William C. Menninger, MC, Chief Neuropsychiatric Consultant in the Surgeon General's Office, and the daily experience of psychiatrists who saw the value of psychodynamics in understanding the characteristic defenses and physical symptoms of people under pressure, whether they be called psychoneuroses, inadequate or undesirable personalities, or some psychosomatic disorder which probably was emotionally triggered. The latter two groups, particularly the psychosomatic population, are not usually cited in the statistics of morale failure due to lack of proper motivation and similar circumstances, but all officers were aware that this was only another facade of the problem of the effective use of manpower.

Because most of the 2,400 psychiatrists in the Army were relatively young, untrained, and inexperienced in Army psychiatry, it is small wonder that there were occasional dissatisfactions expressed by other medical and line officers. The amazing fact is that, although most critics expressed some skepticism about psychiatrists as a group, they were very friendly with the particular psychiatrist with whom they worked. This is a curious phenomenon deserving study. There were a few incompetent psychiatrists, while others did a passable job only in a protected hospital setting. Remarkably few were incapacitated by personal problems of their own as far as can be shown by a review of the record either in the Zone of Interior or overseas, although the canard occasionally persists that this was a problem.

PROBLEMS OF NEWLY INDUCTED PHYSICIANS

The use of technical experts including physicians on a part- or full-time basis was not new in the Army, but the scope of their activity was greatly increased by the fact that this was a much larger Army, with

10,420,000 individuals serving in the Army alone.[12] The rate of growth of this Army between November 1939 from its slow beginning to its peakload in May 1945 with over 8 million persons on active duty was another factor which made some type of technical assistance highly desirable during the turbulent mobilization period. Some service command surgeons were happy to have this help because they had far too many responsibilities to evaluate and supervise technical work or to become familiar with many of the hundreds of new medical officers under their command. Even consultants could only visit installations once in 3 or 4 months in the large service commands.

There was insufficient time for conventional specialty training in 30-day courses in "Field Medicine" such as had been given to groups of physicians at Carlisle Barracks, Pa., for a time after 1 January 1941. The Surgeon General's Office realized early that even this was neither feasible nor necessary for those officers who would not be serving troops. The Medical Field Service School, at Carlisle Barracks, was first established on 1 September 1920 and was a substitute "West Point" for Regular Army medical officers. Now called the Army Medical Service School, after its transfer to Fort Sam Houston, Tex., in 1945, it "is dedicated to the task of preserving the lives and health of American soldiers"—in the words of its motto, "To Conserve Fighting Strength." [13]

Again, it would be of interest to know if the lessons of World War II regarding earlier wars and troop command are being taught here and in other service schools in a manner which will be effective in the next war. At West Point, there is now a Department of Psychology and Leadership which supplements the other training in this area. The author (Brosin) can speak from experience that during his indoctrination at Carlisle Barracks, in April 1941, he learned nothing about field psychiatry; furthermore, the only psychiatrist, Lt. Col. A. Murray DeArmond, MC, on the staff, was an experienced, competent man who had been assigned to the teaching of map reading and was kept at this job most of the year.

Formal Psychiatric Training

In order to indoctrinate newly inducted Army physicians with little or no psychiatric experience who were to be assigned to neuropsychiatric services, they were sent to a newly created (1942) School of Military Neuropsychiatry at Lawson General Hospital, Atlanta, Ga., under the direction of Col. William C. Porter, MC. From December 1943 until December 1945, 3-month courses were given at the Mason General Hospital, Long Island, N.Y.[14] Exactly 1,000 medical officers attended as students and were

[12] The Army Almanac. 2d edition. Harrisburg: The Stackpole Co., 1959, p. 614. (In the Navy, there were 3,883,520; Marines—599,693; Coast Guard—241,093; for the period 7 Dec. 1941–31 Aug. 1945.)

[13] *Ibid.*, p. 190.

[14] Menninger, *op. cit.*, pp. 27–28.

classified and assigned as neuropsychiatrists. Hundreds of others with some neuropsychiatric experience were sent to active general hospital pools where they had some training for brief periods before being permanently assigned.

Informal Psychiatric Training

Education and training in military neuropsychiatry through necessity had to be a continuing process in both administrative and clinical fields. Less than half of the neuropsychiatrists in the Army had attended one of the formal courses given at the three schools, and more than half of these had no training other than the 90-day course (p. 55). Therefore, the neuropsychiatric consultants were in the ideal position not only to foster and encourage inservice teaching but to participate themselves.[15]

Many medical officers with some neuropsychiatric experience were sent to active general hospital pools where they had some training before being permanently assigned.

Officers of all ranks were often kept in such pools from 1 to 4 months to learn both the clinical and the administrative problems of the station they were in and the techniques developed by the Army for handling them. In general, most physicians came to appreciate the need for specified Army procedure and the relative economy of the operations compared to equally complex civilian institutions, in spite of complaints which might give the opposite impression. In fact, with the simplifications in procedures which came in the year after Pearl Harbor, there were very few procedures which could be called unnecessary or wasteful. In some general hospitals, informal courses were held to review Army procedures for admission, transfer, preparation of various board procedures, and correspondence with Army and civilian agencies. Because of the specialized nature of these transactions, workbooks with concrete samples and copies of pertinent regulations were developed and highly prized, particularly by physicians with the rank of major or above who had the responsibility for such procedures. In some cases, officers from other sections of the hospital attended classes and requested copies of such workbooks to assist them in their duties.

Other officers went directly to their assignments in station hospitals, regional hospitals, general hospitals, or induction stations without benefit of any military or professional orientation. Once assigned, however, their training began usually through the chief of the neuropsychiatric service or section under the auspices of the neuropsychiatric consultant. Some chiefs of service or sections distinguished themselves as teachers and greatly eased the path of the new officer who had no preparation for working in a busy wartime Army.

The neuropsychiatric consultant performed his teaching and training

[15] Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants. Volume I. Washingotn: U.S. Government Printing Office, 1961, pp. 102-109, 366-372.

duties in various individual ways but generally followed an established and accepted pattern. In his periodic visits to the various installations in his service command or theater, he either held ward rounds or discussed specially selected problem cases which were presented to him by members of the neuropsychiatric staff. These cases were evaluated as to diagnosis; also, the administrative aspects of each case were discussed.

The neuropsychiatric consultant frequently arrived with new or changed directives concerning neuropsychiatry and was always ready to explain their purpose and use. Among the various professional, administrative, and social reasons why consultants were welcomed was their possession of and knowledge about new directives from the War Department or the service command level. Because of a frequent change of policy at these levels, the necessary vagueness of the wording of the regulations, and their contradictory nature during 1942–44 since manpower policies were not stabilized, consultants were eagerly sought to help interpret and suggest practical implementation of directives. Some consultants also brought with them material for clinical pathological conferences with involved problems of a neurological and psychiatric nature.

On some field trips, the neuropsychiatric consultant was accompanied by a prominent civilian consultant who was an outstanding teacher. The civilian consultant actively participated in the local program prepared for him, and he usually had a message of importance or a particular topic of interest to present. At times, original professional papers were also presented by members of the hospital neuropsychiatric staff. At other times, a "journal club" meeting was arranged to discuss new and provocative psychiatric literature that had been recently published. As a rule, the entire hospital staff was invited to attend these and other meetings with the neuropsychiatric consultant.

The neuropsychiatric consultant conferred with both the chief of the neuropsychiatric service or section and the commanding officer of the unit. By such conferences and from his own observations and impressions, he was able to evaluate the efficacy of the service or section and the capabilities and potentialities of members of the staff. He was then able to advise on present and future assignments of the neuropsychiatric medical officers. In conference with the hospital commander, he could not only discuss the professional activities of his neuropsychiatric personnel but could also point out personnel inequities and needs as well as such administrative procedures as pertained to bed and equipment requirements.

Papers prepared for presentation at meetings or for publication were often reviewed by the neuropsychiatric consultant so that he could expertly assist and advise the author. Occasionally, he would recommend and encourage the preparation of a paper on a particular subject, and he himself contributed to its development.

Thus, the neuropsychiatric consultant in World War II was the stimulating and directing influence in the promulgation of an enduring informal

teaching and training program. Many of these consultants had already served "unofficially" in this capacity either in the Army at different stations or as civilians.

CONSULTANT CONFERENCES

In order to enhance the functioning of the consultant system, on three occasions, conferences were held with the service command consultants in the Surgeon General's Office (figs. 20, 21, and 22). The first such conference occurred on 22 October 1943, at which time there was a joint meeting of the medical and neuropsychiatric consultants. By that date, only four service command neuropsychiatric consultants had been appointed.

The second meeting was held on 12 May 1944, at which time seven of the service command neuropsychiatric consultants had been appointed.

FIGURE 20.—Staff of the Neuropsychiatry Division, Surgeon General's Office, and service command consultants, meeting of 22 October 1943. Left to right, seated: Lt. Col. William C. Menninger, MC, Col. Franklin G. Ebaugh, MC, Brig. Gen. Charles C. Hillman, Col. Roy D. Halloran, MC, and Lt. Col. John M. Murray, MC. Left to right, standing: Lt. Col. Wilfred Bloomberg, MC, Lt. Col. William H. Everts, MC, Lt. Col. Lauren H. Smith, MC, Lt. Col. Malcolm J. Farrell, MC, and Lt. Col. Douglas A. Thom, MC.

On 21 April 1945, a third conference was held, at which time all nine service command neuropsychiatric consultants had been appointed, and this meeting was attended also by the civilian consultants.

FIGURE 21.—Service Command Neuropsychiatric Consultants Meeting, Surgeon General's Office, 12–13 May 1944. Left to right, seated: Lt. Col. Malcolm J. Farrell, MC, Lt. Col. Douglas A. Thom, MC, Col. William C. Menninger, MC, Brig. Gen. Charles C. Hillman, Col. Franklin G. Ebaugh, MC, Lt. Col. Lauren H. Smith, MC, and Lt. Col. Paul L. Schroeder, MC. Left to right, standing: Lt. Col. Clarke H. Barnacle, MC, Maj. Henry W. Brosin, MC, Maj. John W. Appel, MC, Maj. William H. Everts, MC, Maj. Norman Q. Brill, MC, Capt. David W. Hilger, MC, Capt. Ivan C. Berlien, MC, and Lt. Col. Wilfred Bloomberg, MC.

At these conferences, mutual problems were discussed in much detail, plans laid, changes recommended, and experiences exchanged. The consultants were thus able to gain much more of the total perspective of the neuropsychiatric situation, and the neuropsychiatric staff of the Surgeon General's Office could learn firsthand the problems from the field. At the last conference, committees were formed for the purpose of recommending future action, and their recommendations are of special historical significance because here, in the waning months of World War II, a group of senior military psychiatrists condensed their experiences in the form of recommendations (appendix C). Although some of these recommendations may seem irrelevant in future operations, it is considered that these expres-

FIGURE 22.—Service Command Consultants Conference (Neuropsychiatry), Surgeon General's Office, 20–21 April 1945. Left to right, front row: Drs. Edwin G. Zabriskie, Arthur H. Ruggles, and Alan Gregg, Col. William C. Menninger, MC, Drs. Frederick W. Parsons and Edward A. Strecker, and Col. Franklin G. Ebaugh, MC. Left to right, middle row: Lt. Col. Norman Q. Brill, MC, Lt. Col. Lauren H. Smith, MC, Col. William C. Porter, MC, Col. William J. Bleckwenn, MC, Lt. Col. Donald W. Hastings, MC, Maj. John W. Appel, MC, Maj. William H. Dunn, MC, Maj. David W. Hilger, MC, Lt. Col. Walter E. Barton, MC, and Maj. George S. Goldman, MC. Left to right, back row: Lt. Col. Henry W. Brosin, MC, Lt. Col. Clarke H. Barnacle, MC, Lt. Col. Douglas A. Thom, MC, Lt. Col. Paul L. Schroeder, MC, Lt. Col. Wilfred Bloomberg, MC, Maj. Manfred S. Guttmacher, MC, Lt. Col. Morton A. Seidenfeld, MSC, Maj. Ivan C. Berlien, MC, and Lt. Col. Malcolm J. Farrell, MC.

sions of policy, born of intimate contact with the problems, could be of great value in some future conflict to prevent repetition of errors.

CIVILIAN CONSULTANTS

Early in the military effort, provision was made for the appointment of civilian experts as consultants to the Secretary of War on medicine, surgery, and neuropsychiatry. This authority was extended from year to year by the military appropriations acts. It allowed The Surgeon General to utilize, on a part-time basis, the services of highly qualified experts—who were exempt from civil service or classification laws—to provide professional scientific or technical advice, or opinion, in the field of some special knowledge or training. Thus, these services were made available to the Neuropsychiatry Consultants Division.

FIGURE 23.—Neuropsychiatric Consultants to the Secretary of War. Left to right, seated: Arthur H. Ruggles, M.D., Medical Director, Butler Hospital, Providence, R.I.; Maj. Gen. Norman T. Kirk, The Surgeon General of the Army; and Alan Gregg, M.D., Medical Director, The Rockefeller Foundation, Washington, D.C. Left to right, standing: Frederick W. Parsons, M.D., former Commissioner of Mental Health, State of New York; Brig. Gen. William C. Menninger, Director, Neuropsychiatry Consultants Division, Office of The Surgeon General; Edward A. Strecker, M.D., Professor of Psychiatry, University of Pennsylvania; and Edwin G. Zabriskie, M.D., Professor of Neurology, College of Physicians and Surgeons, New York.

Early in 1944, the director of the division requested that The Surgeon General approve the appointment of civilian consultants in the field of neuropsychiatry (fig. 23). In order that there would be some direct relationship to the organized group of civilian psychiatrists, the American Psychiatric Association was approached to appoint a committee to act as consultants representing that organization. Utilization was made of an

already standing committee known as The Special Committee on Psychiatry in the Armed Forces, composed of Drs. Arthur H. Ruggles, Edward A. Strecker, Frederick W. Parsons, and Karl M. Bowman. Drs. Strecker and Parsons had been appointed as such in August 1943 for other special projects which were at that time under consideration. The committee representing the American Psychiatric Association was officially appointed to counsel with the Neuropsychiatry Consultants Division. To this number was added Dr. Edwin G. Zabriskie, on 10 May 1944, as a representative of the American Neurological Association, of which he at that time was president. On 24 June 1944, Dr. Frederick A. Gibbs was appointed as a special consultant in electroencephalography. On 16 April 1945, Dr. Alan Gregg, of the Rockefeller Foundation, was appointed as a consultant in neuropsychiatry to the division.

This group of consultants met on call of the director of the division to consider special problem or problems concerning neuropsychiatry in the Armed Forces. Their opinion and guidance was solicited and freely given. This group met first on 7 April 1944; again, on 28 June 1944, on 23 August 1944, on 25 January 1945, and on 19 July 1945. The final meeting was held on 19 February 1946. Periodic reports were made by them to the American Psychiatric Association and these were printed in the official journal, *American Journal of Psychiatry.*

Throughout 1944, consultant help was gained from Mrs. Elizabeth H. Ross, then the Secretary of the War Service Office of the American Association of Psychiatric Social Workers, jointly sponsored by the American Association of Psychiatric Social Workers and the National Committee for Mental Hygiene, with headquarters in Philadelphia. From this office, Mrs. Ross graciously and generously advised the division with regard to psychiatric social work. Late in 1944, for lack of funds, her office was threatened with closure, and in order that the Army might continue to have her services, she was officially appointed on 16 December 1944, as Consultant to the Secretary of War in Psychiatric Social Work, in which capacity she continued to serve as a consultant throughout 1945 and in the early months of 1946.

Other kinds of civilian consultants were appointed for specific hospitals. A shortage of capable, older psychiatrists and neurologists had always existed in the Army. On the other hand, there were many civilian physicians who, although they had been declared essential in their civilian jobs, were nonetheless anxious to contribute to the war effort. In order to meet in some degree the shortage of psychiatrists and neurologists in the Army, and to take advantage of the assistance offered by the civilians in this group, arrangements were made whereby outstanding men could be appointed within a service command to act as consultants and teachers to a specified hospital.

On 30 January 1945, the Director of the Neuropsychiatry Consultants

Division, in a memorandum to Brig. Gen. Raymond W. Bliss, set forth the request for this plan, which was approved:

1. Regardless of the number of medical officers that may be assigned to us for use in neuropsychiatry, we shall be hard pressed. We have utilized civilian psychiatrists in induction centers with fair success. We recognize many handicaps in the attempt at utilization of civilian psychiatrists in other positions, and yet believe that many could give some very valuable service. The matter has been discussed with our civilian consultants and with our service command neuropsychiatric consultants, all of whom question the success of such utilization, but feel that we should establish the machinery for such.

2. I wish to make the following recommendations:

a. That the service command neuropsychiatric consultants, under the authority and with the approval of the service command surgeons, be authorized to appoint one or more civilian psychiatrists, the number to be determined by the men available, the need and the facilities for utilization of such men.

b. That such civilians be under the supervision and assignment of the service command neuropsychiatric consultants.

c. That such individuals appointed might be employed up to a maximum of one-half time, though it may be anticipated that some will be used only a few days a month, some only periodically.

d. The possible duties might include:

(1) Regular assigned therapeutic work in convalescent or general hospitals, out-patient department, mental hygiene consultation service, or redistribution center.

(2) Regularly assigned diagnostic work in any of these installations.

(3) Special jobs such as teaching, ward rounds, counseling regarding diagnostic or treatment measures, and consultation on special cases.

Not many men were so appointed, chiefly because of the inherent difficulties of attempting to use civilians who had had no military experience in a military hospital. Many of the knottiest problems confronting the military neuropsychiatrists were concerned with military policy and practice, and in this field, the civilian consultants could be of no help. It was an uphill task for military psychiatrists everywhere to gain the confidence and respect of many of the oldtime Regular Army officers. It was believed that in some hospitals a civilian consultant might be regarded as an intruder. Despite the many obstacles, this plan worked excellently in a few hospitals.

RECOMMENDATIONS AND CONCLUSIONS

It is unrealistic to make recommendations for the corrections of errors which may never be made again. There is no doubt that some effective corrective measures have occurred. It seems unlikely that the next war will be similar to the last one and therefore energy should be devoted to anticipating the needs of the next war in its various forms. Because past experience may be of value to those with planning responsibility, the following recommendations are offered from the experience of many of our consultants, although not all of them would concur in all topics:

1. Manpower should be conserved as far as feasible by good prewar planning to match the record of procurement and supply.

2. Health and morale are functions of command.

3. The consultant system, unanimously approved, deserves continuance from a central office in the Professional Division, Office of The Surgeon General, to consultants in the field. More outstanding middle-aged specialists should be encouraged to take these positions.

4. It would be well for the military medical services to develop sufficient regular medical officers to serve as consultants. Even the most experienced civilian consultant must go through a transition when assigned in a military setting, in order to be aware of the various operational problems of the military milieu, the military organization, the channels of transmission, even the assimilation of military language. This takes time and mistakes may be made. The Regular Army medical consultant because of his past contacts and experience could better establish liaison and easier accessibility with other medical or tactical agencies. During peacetime, the Regular Army consultant could insure that the lessons learned in previous wars would not be lost by means of establishing and continuing proper policies in regulations, technical manuals, and training doctrines.

5. It was found advisable to have conferences with the service command consultants. Any future program should provide for regular established meetings of the group in the Surgeon General's Office to develop and maintain the close contact with their own professional divisions as well as all other services and divisions in the Surgeon General's Office.

6. A more effective system of selective service should be developed.

7. Consideration should be given to a preliminary trial of inductees analogous to the period of "boot-training" in the Navy.

8. Neuropsychiatric specialists might work with profit with line officers in maneuvers to develop the best methods of caring for soldiers with "battle fatigue." Medical officers must earn the right to help in field activities.

9. Realistic instruction regarding the psychology of leadership, morale, and "the ineffective soldier" should be added to the already splendid indoctrination received by line officers in special service schools. Brief academic consideration, no matter how well taught or received, will not replace some actual experience. An analogy might be drawn to the necessary clinical experience received by medical students, interns, and residents. Methods or prevention and rapid treatment suitable to large groups should be developed systematically.

10. Better methods for the selection, assignment, transfer, promotion, and separation of Medical Department personnel are essential. This is especially true for the separation of the ineffectual officer.

11. Better communication between all echelons are essential for efficient service.

12. The W–8 type of hospital ward must be replaced by a new design.

New hospital construction should conform to the best civilian standards with facilities for adequate outpatient care, and ample usable space for the newer laboratories and treatment.[16]

13. Better methods of statistical reporting of local hospital admissions to the service command headquarters would permit the surgeon to control such admissions and to distribute them more judiciously.

14. Improved methods of administrative discharge of the ineffective soldier as well as better methods of dealing with homosexuals, prisoners, and the antisocial persons are necessary. Since World War II, much progress has been made in this area.

15. Insofar as feasible with military requirements, make provisions for a more stable cadre of nurses and other paramedical personnel in at least the larger hospitals in order to permit these small teams to do good work. The neuropsychiatry sections were usually at a disadvantage as compared with the medical and surgical services, because the more unstable or undesirable nurses or aids were assigned to the neuropsychiatric section, sometimes with the justification that they would receive closer supervision.

16. Public relations methods should be developed to improve morale.

17. While the responsibility for psychological welfare is not ours, it seems obvious that this area in which some work is being done needs development.[17]

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[16] Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956.

[17] Dyer, Murray: The Weapon on the Wall; Rethinking Psychological Warfare. Baltimore: Johns Hopkins Press, 1959.

CHAPTER VI

Liaison With Other Agencies

Malcolm J. Farrell, M.D.

SCOPE

The relationships of the Neuropsychiatry Consultants Division, SGO (Surgeon General's Office), to other agencies increased from almost none, early in 1942, to such prevalence as to be impractical of detailed description. This division was concerned with a major source of manpower loss which confronted the Medical Department and the War Department. It dealt with intangible subjects which had captured a tremendous amount of public interest and concern. Further, it was the sole source of professional advice in the War Department on problems of the mental health of personnel. As a result, more and more demands were made on the division by public, governmental, and military agencies. Therefore, the personnel of the division were increasingly occupied with matters of training, personnel policies and procedures, morale, military justice, rehabilitation, and, later, the problems of redeployment, not to mention the growing difficulties of providing satisfactory treatment for neuropsychiatric patients. Further, representatives of the division were called upon more and more to prepare staff studies and to participate in surveys by other War Department agencies. All of these activities resulted in an increased liaison with these agencies.

OFFICE OF THE SECRETARY OF WAR

Close liaison was established early in the Office of the Secretary of War, particularly through Mr. Harvey H. Bundy, Sr., Special Assistant to the Secretary. Mr. Bundy kept that office informed on special projects and, by making well-timed requests for information or by expressing interest in certain areas, called these projects to the attention of higher headquarters. Thus, early in 1943, a brief summary of the progress made in the Neuropsychiatry Branch (later, Neuropsychiatry Consultants Division) during its first year of organization was dispatched in the form of a memorandum.[1] This memorandum stressed the efforts made in the following areas: Neuropsychiatric examinations on induction and mobilization, Army regulations, and circular letters for guidance; the use of

[1] Memorandum, Lt. Col. Malcolm J. Farrell, MC, Assistant Chief, Neuropsychiatry Branch, Surgeon General's Office, for the Assistant Secretary of War, 13 Feb. 1943, subject: Nervous and Mental Diseases in the Army.

mental hygiene clinics and other outpatient neuropsychiatric activities in replacement training centers; the training of military neuropsychiatrists in general hospitals and at the School of Military Neuropsychiatry; the use of lectures and the plans for using films on various Army posts to give a better understanding of fear and anxiety. It stressed that this war was different and required newer methods and concepts of operation.

Later, Mr. Bundy [2] expressed the interest of the Secretary of War in the psychoneurotic problem in the Army, and said: "It is my understanding from the various reports and studies which have been made that the problem is primarily one of command and that there is need to educate the officers with troops of their relationship to the problem." He referred to the possible expansion of training and morale pamphlets and the possible use of motion pictures. Although, in his reply, Maj. Gen. Norman T. Kirk,[3] The Surgeon General, did not mention the War Department technical medical bulletins [4] which were already in use, he did infer that morale was a command problem and that his office was assisting the Morale Services Division, ASF (Army Service Forces), with technical advice.

Office of the Under Secretary of War.—Col. (later Brig. Gen.) William C. Menninger, MC, Director, Neuropsychiatry Consultants Division, made excellent contact with Brig. Gen. Edward S. Greenbaum, Executive Officer, Office of the Under Secretary of War. Because of this close liaison, it was possible, in response to an informal request, to send a frank, pertinent 7-page letter containing comments and suggestions regarding the discharge of neuropsychiatric patients.[5]

This letter included a frank report from Italy, which bluntly spelled out some of the reasons for the lowered morale and bitter feelings found among many casual replacements. Based on these data, it was strongly advised that consideration be given to four major issues: Motivation, leadership, job assignment, and rotation policy. Further suggestions were made regarding procedures at the time of discharge; the use of proper caution in maintaining the confidentiality of the discharge diagnosis; and rehabilitation, including overall responsibilities, coordination, and educational efforts. Subsequent events, procedures, and even regulations showed that this close liaison and especially this letter had considerable influence upon the molding of command policies.

In the Office of the Under Secretary of War, Col. Marion Rushton, JAGD, a lawyer with unusually keen insight regarding psychiatry, maintained a close liaison between the branch he represented and the Neuro-

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[2] Memorandum, Harvey H. Bundy, Special Assistant to the Secretary of War, for The Surgeon General, 2 Aug. 1944, subject: Psychoneurotics in the Army.

[3] Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, for Mr. Harvey H. Bundy, Special Assistant to the Secretary of War, 9 Aug. 1944, subject: Psychoneurotics in the Army.

[4] (1) War Department Technical Bulletin (TB MED) 12, 22 Feb. 1944. (2) War Department Technical Bulletin (TB MED) 21, 15 Mar. 1944.

[5] Letter, Col. William C. Menninger, MC, Director, Neuropsychiatry Division, Surgeon General's Office, to Brig. Gen. Edward S. Greenbaum, Executive Officer, Office of Under Secretary of War, Washington, D.C., 9 May 1944, subject: Discharge.

psychiatry Division. He was especially concerned with discipline, disciplinary barracks, and rehabilitation centers and was also interested in the salvageability of military offenders with psychiatric disorders.[6] In March 1944, Capt. (later Maj.) Ivan C. Berlien, MC, of the Neuropsychiatry Consultants Division, was designated as liaison officer to work with Colonel Rushton on disciplinary problems.

As the contact grew, it resulted in the referral of more individual problem cases for solution, particularly medicolegal problems, and in the development of an Army-wide policy regarding military prisoners. In May 1944, at a Seventh Service Command conference, the question of routine neuropsychiatric examination of all enlisted men prior to general courts-martial was raised.[7] At the time, the Neuropsychiatry Consultant Division's liaison officer stated that routine neuropsychiatric examination was not feasible because of (1) the shortage of neuropsychiatrists, (2) the large number of general prisoners, (3) the very limited number of accused soldiers in whom mental competency was an issue, and (4) the increased time that courtroom testimony would expend for an already limited psychiatric staff. Consequently, the need for pretrial neuropsychiatric examination was left to the discretion of the court as clearly stated in the courts-martial manual.[8]

At the Under Secretary's "Conference on the Rehabilitation of Military Prisoners," Fort Leavenworth, Kans., 14–16 November 1944, the Director, Neuropsychiatry Consultants Division, proposed a "12-point" program for the participation of neuropsychiatry in the formulation and operation of an effective rehabilitation program (pp. 502–503).

A uniform clemency policy for military prisoners with neuropsychiatric disorders was also developed. The chief points of this policy were (1) to recommend clemency for those prisoners who obviously were too feebleminded to make possible their restoration to duty and (2) to recommend for clemency only those who were not antisocial to the extent that the Army would be releasing a menace to the community to which the men returned.

The Neuropsychiatry Branch was likewise active in implementing the efforts of the Bureau of Prisons, U.S. Department of Justice, in conjunction with the Selective Service System to rehabilitate and induct certain qualified Federal prisoners and certain ex-officer prisoners of the U.S. Disciplinary Barracks, Fort Leavenworth.

Further psychiatric participation in disciplinary problems included psychiatric orientation of every officer and enlisted man associated with the

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[6] Memorandum, Capt. Ivan C. Berlien, MC, for Col. William C. Menninger, MC, Director, Neuropsychiatry Division, Surgeon General's Office, 27 Apr. 1944, subject: Liaison With War Department.

[7] Memorandum, Maj. Ivan C. Berlien, MC, for Col. William C. Menninger, MC, Director, Neuropsychiatry Division, Surgeon General's Office, 23 Aug. 1944, subject: Neuropsychiatric Examination of Enlisted Men Brought Before GCM [General Courts-Martial].

[8] A Manual for Courts-Martial, U.S. Army. Washington: U.S. Government Printing Office, 1 Apr. 1928.

rehabilitation of prisoners, and increased emphasis upon the return to duty from disciplinary barracks and centers.

One of the outstanding advances made during the previous year was the development and increased emphasis placed upon group therapy in the rehabilitation centers, thus making it possible for psychiatrists to reach many more men therapeutically.[9]

PERSONNEL DIVISION, G–1

Psychiatric Rejections

Perhaps, the most important problem which concerned the Neuropsychiatry Consultants Division and the Personnel Division, G–1, War Department General Staff, was the number of psychiatric rejections at induction.

The following memorandum illustrates the difficulties in this area:

WAR DEPARTMENT
WAR DEPARTMENT GENERAL STAFF
Personnel Division G–1
Washington

5 AUGUST 1943

WDGAP 201.5
MEMORANDUM FOR MILITARY PERSONNEL DIVISION, ASF:
Subject: Rejection of mental cases at induction stations.

1. Attention is invited to the inclosed summary which indicates that 9 percent of the total number of men processed during the month of June were rejected for psychiatric reasons. This rate of rejection is creating unfavorable public reaction, and has aroused criticism in the Selective Service System. It is further reported that such procedure is providing a haven for malingerers and other individuals who seek to evade service with the Armed Forces.

2. It does not appear reasonable to this Division that approximately 1 out of every 10 men who are presented at induction stations are psychotic to a degree which would disqualify them for military service or justify the assumption that they may become charges of the Government.

3. The Secretary of War directs that an immediate investigation be made of the procedure currently followed at induction stations in interpreting the instructions pertaining to rejections for mental causes, that remedial action be initiated without delay and necessary corrective measures not within the authority of the Commanding General, ASF, be referred to the Assistant Chief of Staff, G–1, for further corrective action.

/s/ M. G. WHITE,
Major General,
Assistant Chief of Staff.

Upon the receipt of this memorandum, Brig. Gen. George F. Lull, the Deputy Surgeon General, with the assistance of Col. Roy D. Halloran, MC, Chief, Neuropsychiatry Branch, submitted by endorsement,[10] a preliminary report, in which the following was proposed:

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[9] A complete description of psychiatry in correctional institutions is given in chapter XVII, "Psychiatry in the Army Correctional System."

[10] Memorandum, Maj. Gen. M. G. White, Assistant Chief of Staff, G–1, for Military Personnel Division, ASF, 5 Aug. 1943, subject: Reduction of Mental Cases at Induction Stations; 1st indorsement thereto, 18 Aug. 1943.

* * * that a Committee of nationally recognized civilian neuropsychiatrists, together with the Chief of the Neuropsychiatry Branch of this office, be appointed to conduct an investigation of induction procedures and make appropriate recommendations, in compliance with paragraph 3 of basic communication. This Committee will consist of Drs. Winfred Overholser, Superintendent of Saint Elizabeths Hospital, Washington, D.C.; Arthur H. Ruggles, past President of the American Psychiatric Association, Providence, R. I.; Frederick W. Parsons, former Commissioner, Department of Mental Health, New York, N.Y.; Raymond W. Waggoner, Professor of Psychiatry, University of Michigan, and neuropsychiatric consultant to the Selective Service Headquarters, Washington, D.C.; Karl M. Bowman, President-elect of the American Psychiatric Association, and Director of the Langley Porter Clinic, San Francisco, Calif.; Titus H. Harris, Professor of Psychiatry, University of Texas, Austin, Tex., and Colonel Roy D. Halloran, MC, Chief of the Neuropsychiatry Branch of the Army.

In this preliminary report, The Surgeon General also endeavored to rebut the statements made in the original communication from G–1, pointing out that, in June 1943, neuropsychiatric discharges comprised 38.4 percent of all medical discharges. Although this was more than five times as great as the next single cause, it did not cover all neuropsychiatric disorders, since many more were discharged under section VIII, AR (Army Regulations) 615–360. It noted that neuropsychiatric casualties in oversea theaters were running higher than the American Expeditionary Forces rate in World War I, "in spite of the fact that in this war 6–9 percent of all men examined at induction centers are rejected for neuropsychiatric reasons, whereas, only 2 percent were so rejected in the last war." This induction rate of rejection, the 6–9 percent also, included—

* * * those with a history of treatment for a mental condition, psychopaths, alcoholics, the mentally deficient, homosexuals, and emotionally unstable persons who are frequently diagnosed as psychoneurotics and who cannot make any adjustment to military life, especially under combat conditions. These individuals are chronic troublemakers, have a very detrimental influence on others, and are actually dangerous in many instances. Constant appeals are coming from overseas to prevent the induction and oversea shipment of these types.

Regarding psychoses and malingering, the preliminary report stated: "Actually, relatively few psychotic individuals appear at the induction board, and * * * malingering is the exception rather than the rule." Further, in response to the specific issue of excessive psychiatric rejections raised by G–1, the preliminary report stated: "* * * this office has been considering the advisability of increasing rather than decreasing the stringency of the neuropsychiatric induction screening process." [11]

The committee, as proposed, was appointed, and in the brief time allotted to the members, they not only covered every service command and interviewed many persons at all levels of the Army but also submitted a brief but comprehensive lucid report with far-reaching effects (appendix D), which essentially supported The Surgeon General's position as expressed in the aforementioned rebuttal.

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[11] It is pertinent to note that the belief in the efficacy of psychiatry screening "died hard." It was still believed to be the answer to the vast increased incidence of neuropsychiatric disorders.—A. J. G.

Since The Surgeon General was frequently contacted, formally and informally, concerning the personnel problem, the Consultant in Neuropsychiatry attempted to keep him informed of current situations and progress. A very good and comprehensive example of such a communication was "Extent of Neuropsychiatric Problems in the Army," dated 15 June 1944 (appendix E, p. 807).

Psychiatric Admissions and Discharges

Even as late as the fall of 1944, considerable concern was still being expressed about the large number of neuropsychiatric casualties. Speculations were made as to the causative factors, especially the possibility of overzealousness among psychiatrists.

Apparently, an article appearing in the 23 September 1944 issue of *Collier's* magazine, entitled "Repairing War-Cracked Minds," lent stimulus for further investigation. The Assistant Deputy Chief of Staff [12] requested "* * * that G–1 study the problem to determine what improvements can be made in our procedures and publicity in the handling of psychoneurotics." This memorandum particularly mentioned that Army psychiatrists "* * * are overdoing their diagnosis of psychoneurosis and are overdoing the publicity on this subject."

Since G–1 forwarded the memorandum to The Surgeon General, the Neuropsychiatry Consultants Division embarked upon another study which consumed many hours during the fall of 1944.

The Surgeon General's viewpoint

In reply, the first of a series of memorandums was submitted by The Surgeon General to G–1 on 10 November 1944 (appendix E, p. 814). This memorandum dealt mainly with the diagnosis and treatment of psychoneurosis, including published material and directives, as was specified in the instruction from G–1 and did not go into the matter of prevention to any great length, nor did it supply specific recommendations as these had not been requested. Upon receipt of this memorandum, Lt. Col. Westray B. Boyce, WAC, who was the staff officer of G–1 during this study, stated that a second memorandum was desired which would place emphasis on prevention and make specific recommendations. It is believed that this second request represented an important change in thinking on the part of G–1 and the War Department.

In the course of subsequent joint conferences in this area and as a result of the information presented in the various memorandums that were supplied, along with an earlier NATOUSA (North African Theater of Operations, U.S. Army) memorandum and articles in *Health*, it became

[12] Memorandum, Assistant Deputy Chief of Staff, for the Assistant Chief of Staff, G–1, 28 Sept. 1944, subject: Psychoneurotics.

apparent to G–1 that psychiatrists were not the cause of psychiatric cases and that, if anyone was responsible for their occurrence, it could be command itself, since command controlled the factors which determined mental health of military personnel. This second request could be thought of as representing the War Department's acceptance of the command's responsibility in the psychiatric problem. Further, it sought advice from The Surgeon General on what could be done in policies and procedures which would decrease the loss of manpower from this cause. The reply to G–1's request was prepared and submitted on 7 December 1944 (appendix E, p. 817).

The Inspector General's investigation

Meanwhile, the Inspector General had been called into the picture and instructed to conduct a major investigation of psychoneurosis in the Army. Maj. Gen. Howard McC. Snyder, Brig. Gen. Orval R. Cook, Col. Glen C. Salisbury, and others representing the Inspector General's Office held preliminary conferences with the personnel of the Neuropsychiatry Consultants Division and then proceeded with their investigation. They enlisted the aid of five civilian psychiatrists who were duly sworn in and accompanied the representatives of the Inspector General's Office in their field inspection trips. The members of this committee were as follows:

Dr. Karl M. Bowman, Professor of Psychiatry, University of California School of Medicine; Director of the Langley-Porter Psychiatric Clinic, San Francisco, Calif.; President of the American Psychiatric Association.

Dr. C. Charles Burlingame, President, The Institute of Living, Hartford, Conn.; Chairman, Committee on Public Education, American Psychiatric Association; Associate in Psychiatry, Columbia University, New York, N.Y.

Dr. Frank Fremont-Smith, Director, Josiah Macy, Jr. Foundation, 565 Park Avenue, New York, N.Y.

Dr. Harry C. Solomon, Professor of Psychiatry, Harvard Medical School, Cambridge, Mass.; Director, Boston Psychopathic Hospital, Boston, Mass.

Dr. Edward A. Strecker, Professor of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.; Member of the Advisory Committee on Psychiatry to the Secretary of War and the Secretary of Navy.

Report of investigation.—The Inspector General presented his report on 17 December 1944.[13] An interesting statement contained on page 5 of this report is as follows: "Actually, the majority of these cases are not neuropsychiatric conditions because medical officers wish to make patients

[13] Report, The Inspector General, to Assistant Chief of Staff, G–1, 17 Dec. 1944, subject: Psychoneurotics.

out of them, but because the line officers have been unable to make soldiers out of them."

The conclusions (recommendations) contained in this Inspector General's report are as follows:

CONCLUSIONS:

1. That the term "Psychoneurosis" has been abused and becomes a stigma because of its indiscriminate use in the Armed Forces.

2. That too many ineffectives are still being accepted at induction stations, which situation might be improved if commanding generals of the service commands were instructed to issue directives to the induction stations in their commands to reject a selectee if there is reasonable doubt of his meeting the physical and mental qualifications for full duty.[14]

3. That psychiatrists should place emphasis on eliminating, during the early period of training at replacement training centers, inadequates and those who are militarily inadaptable, and thereafter concentrate their attention toward building morale and adjusting men as effective soldiers. The diagnosis of "Psychoneurosis" should not be utilized in the discharge of such soldiers, in consequence of which they are enabled to draw compensation without in any way having contributed to the war effort while in the service.

4. That a large proportion of the medical discharges for "Psychoneurosis" have been brought about because of the difficulty experienced by line officers in effecting the administrative discharge of inadequates and of persons inadaptable to the service.

5. That there are at present an insufficient number of psychiatrists, psychiatric social workers and clinical psychologists in the Army to carry on an adequate program of preventive psychiatry and, therefore, that the number of this type personnel undergoing training at psychiatric schools should be increased.

6. That the term "Operational Fatigue" is acceptable as applied to individuals who have broken down under combat stress or other hazardous conditions, but should be limited in duration to only a few weeks and should not be used as a discharge diagnosis.

7. That the discharge diagnosis of "Psychoneurosis" should not be used for those individuals whose psychoneurotic condition is (a) doubtful, borderline, or mild, and (b) whose prognosis is favorable, and in those cases where recurrence, medical care, or hospitalization for the condition is unlikely.

8. That men breaking down in combat or in hazardous situations should receive the maximum benefits of hospitalization and convalescent facilities, which must include physical and psychological rehabilitation, vocational guidance, pre-vocational training, and resocialization, and to this end there should be established additional special treatment centers.

9. That inadequate individuals who have demonstrated inadaptability to the military service but who are not psychoneurotics in the true meaning of the term should be discharged administratively under the provisions of AR 615–369 as "Inadaptable to the Service," and not be afforded the dignity of a medical diagnosis.

10. That individuals who have suffered from "Operational Fatigue," and from whom further productive service appears unattainable, should be released to the inactive reserve for a period of not less than one year, and not only encouraged but assisted in entering a gainful occupation, or in resuming their formal education.

11. That full publicity of the psychiatric problem should be given in a factual manner, but directed toward showing that the huge number of men previously discharged with this diagnosis from the Army were, as a matter of fact, unfit for military duty or psychiatrically ill at the time of their induction; and, conversely, that those who were

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[14] Even at this late date, the erroneous belief persisted that the psychiatrist had the capability of effectively identifying the potential psychiatric problem at the induction station.—A. J. G.

not thus eliminated or found to be unfit have behaved magnificently under the most trying conditions, together with the fact that the better the human material, the higher the breaking point.

In this report were included the views of the Inspector General, as follows:

It is believed that the subject of "Psychoneurosis" as affecting military personnel should not be regarded solely from a medical viewpoint because many line officers also came in daily contact with the problem, and knowingly or otherwise, they are, to a great extent, responsible for the degree of psychoneurosis which develops within their respective commands. It was for this reason that there were included in the group of officers and specialists conducting this inquiry several line officers with considerable combat and troop duty experience. The views of these line officers were given full consideration during the preparation of General Snyder's report, and many of their ideas were incorporated therein, along with those of general medical officers and the eminent psychiatrists called in for consultation. This, it is believed, has resulted in a balanced consolidation of opinions without too great influence being exerted by the professional viewpoint of neuropsychiatrists. Therefore, I concur in the conclusions arrived at, and recommend that they be given consideration in the study on psychoneurosis now being prepared by the Assistant Chief of Staff for G–1. However, because of the importance of this subject, and of its increasing effect on the Army as the war is prolonged, it is believed that this study should be continued or extended, and that The Inspector General be authorized at an appropriate time to send officers to both the European and Southwest Pacific Theaters of Operation for this purpose.

/s/ VIRGIL L. PETERSON,
Major General,
Acting The Inspector General.

Disagreement.—There now remained for G–1 the task of bringing together all these reports into a single document that would contain recommendations asked for by the Deputy Chief of Staff in his initial instructions. Although the various reports agreed on certain points, there was marked disagreement on certain other points. The chief disagreement between The Surgeon General and G–1 was as follows: [15]

* * * * * * *

2. Generally TSG [The Surgeon General] and G–1 are in agreement on all points covered in this study except three major issues as follows:

a. TSG is opposed to the recommendation of TIG [The Inspector General] and G–1 for the use of the working diagnosis of "Combat Fatigue" or "Operational Fatigue," for individuals who have broken in combat or under unusually hazardous duty to avoid the impediment of a psychoneurotic label for those who are returned to duty within a reasonable period of time. In lieu thereof, TSG recommends working and discharge diagnoses of the particular types of psychoneuroses without reference to the word "psychoneurosis," which is considered by G–1 to be just as much of an impediment.[16]

b. TSG is opposed to the recommendation of TIG and G–1 to prohibit the use of the diagnosis of psychoneurosis except for individuals whose psychiatric condition

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[15] Memorandum, Assistant Chief of Staff, G–1, to Deputy Chief of Staff, 4 Feb. 1945, subject: Psychoneurotics.

[16] Apparently, the practical benefits of using special diagnostic terms for the emotional disorders of combat stress during the earlier phase of these stress reactions was better appreciated in oversea theaters than in the Surgeon General's Office. For example, in April 1943, II Corps in North Africa directed that the

is such as to warrant discharge on CDD (AR 615–361). TSG believes the use of the working and discharge diagnoses of the particular types of psychoneurosis should be permitted regardless of whether the individual is incapacitated for military duty or civilian life, as the case may be. TIG and G–1 feel that the resulting impediment of such entries in the medical record of those who are not incapacitated is an injustice and should be prohibited.

c. TSG is opposed to the G–1 recommendation that all inapt, inadequate or inadaptable individuals be initially processed under AR 615–361, which requires a medical board to determine whether they are psychoneurotic in the true sense of the term and warranting medical discharge, or merely incapable of adjusting to military service and warranting administrative discharge. TSG feels that the opinion of one psychiatrist is sufficient medical judgment for the board of line officers appointed to consider such administrative discharges. G–1 is of the opinion that a hospital board of medical officers is desirable in order that definite conclusions will be rendered after a period of observation and treatment.

The issue presented in paragraph 2b of this memorandum was of particular concern to The Surgeon General because it permitted laymen rather than physicians to make medical diagnoses and forced physicians to put arbitrary nonmedical terminology on medical records. There was strong resistance in the Surgeon General's Office to this, including that of General Lull.

Resolution.—The Deputy Chief of Staff, on learning of the nonconcurrence of The Surgeon General in the G–1 memorandum, presented previously, instructed the various agencies concerned to get together and propose a set of recommendations which were mutually agreeable to all. After a series of long and interesting conferences, this was accomplished, and a memorandum [17] was sent forward having been concurred in by The Surgeon General, the Inspector General, the Air Surgeon, and G–1. Pertinent extracts of this memorandum are as follows:

4a. (1) That the term psychoneurosis has been employed too widely and indiscriminately in the Army. This has resulted in part from a widespread tendency to use medical channels of evacuation, reclassification and discharge in order to eliminate undesirable or inadaptable personnel.

(2) It was agreed that the term "psychoneurosis" should not be used in individual clinical records in the Army and that the medical term for the particular types of psychoneurosis (such as "anxiety reaction") be used, together with a brief

initial diagnosis for all combat induced emotional disturbances was to be "Exhaustion." The advantages were:

1. No specific "etiology" was implied (as was the case in World War I with "shell shock" and in World War II with "psychoneurosis").

2. Without resort to euphemism, this term "exhaustion" reduced feelings of unacceptable failure in such casualties. Combat *was* subjectively fatiguing to almost all soldiers, and thus, "exhaustion" was a logical designation.

3. Implied reversibility of "exhaustion" with a brief period of adequate rest followed by a few days of reconditioning supported the success attained in the program that was actually instituted for these casualties.

4. Early symptoms, judged in the light of brief personal histories, represent a poor basis for formal psychiatric diagnoses. After 5 to 7 days, the condition of those casualties who were unable to return to combat could be better defined clinically, and thus, a formal psychiatric diagnosis could be made more accurately. Such accuracy in diagnosis increased when the soldier was evacuated farther to the rear for more definitive psychiatric care.—A. J. G.

[17] Memorandum, Assistant Chief of Staff, G–1, for the Deputy Chief of Staff, 16 Feb. 1945, subject: Psychoneurotics.

description of individual, type and amount of stress which induced the condition and the effect (if any) upon his functional capacity.

b. No diagnosis as indicated in par 4a (2) above should be entered on report of final physical examination of an individual being processed for administrative discharge unless so determined by a board of medical officers.

(1) Those noneffective individuals who are not sick and not in need of medical treatment should be returned to duty with a statement to this effect.

(2) Those who have received maximum benefit of treatment, who have no condition which warrants disability discharge but are inadaptable to military service should be discharged administratively.

c. Upon maximum benefit of medical treatment those individuals whose condition is such as to warrant medical discharge will be so discharged under existing CDD procedure with diagnosis as indicated in par 4a (2) above.

d. Release to the inactive reserve of those individuals who have become temporarily inadaptable to further military service as a result of stress experienced in combat was considered and strongly recommended. However, this question is integrated with the present study now being made of "Utilization of Returnees." It is believed this phase should be studied after full information is available from the study referred to.

e. In view of the manpower situation and the increasingly high rejection rate for neuropsychiatric disorders, registrants should be rejected only after definite evidence that they are below acceptance standards.

f. It was concluded that there are insufficient trained psychiatrists, psychologists and psychiatric social workers in the Army.

g. It was concluded that additional separate special treatment centers for handling combat-induced psychoneurotic patients not be established.

h. Part of the confusion on the part of the public about the subject of psychoneurosis has been due to the complete black-out of publicity by the Joint Security Control Board of the Army and Navy until May 1944. Since then only fragmentary information has been released. It was agreed that publicity insofar as possible should be given in a factual, nontechnical manner.

i. Lack of motivation toward fighting the war has been a basic cause for the high incidence of ineffectiveness and psychoneurosis in military personnel.

This was duly approved by the Chief of Staff personally and by the Secretary of War who stated that he thought it a "sensible solution" to the problem. A summary of the report was also sent to the Commander in Chief who replied as follows:

25 March 1945.

My dear Mr. Secretary:

Thank you for your letter of February 28, 1945, in which you further outline the scope of the psychiatric problem in the Army.

I fully appreciate the magnitude of the task of caring for the soldier who is emotionally sick as a result of combat, as well as the man whose service maladjustment is but a reflection of a long existent inadequacy.

It would seem that your program provides equally well for both groups and should be a material aid in their ultimate civilian adjustment.

Sincerely yours,
/s/ Franklin Roosevelt

The Honorable Henry L. Stimson,
Secretary of War, Washington, D.C.

Result.—WD (War Department) Circular No. 81, dated 13 March 1945, appeared shortly after the investigation and represented the chief immediate result of this study. It is an interesting sidelight that section III of this circular was taken almost word for word from the paper presented by Lt. Col. Malcolm J. Farrell, MC, and Maj. John W. Appel, MC, to the American Psychiatric Association the preceding spring, entitled "Current Trends in Military Neuropsychiatry." [18]

It was not until the magnitude and nature of the neuropsychiatric problems were dramatically brought to the attention of G–1, through the many investigations in which Colonel Boyce was personally involved, did close liaison develop between the two divisions (p. 102). When the assignment of Colonel Boyce as Director of the Women's Army Corps was anticipated in July 1944, Maj. Gen. Guy V. Henry, Assistant Chief of Staff, G–1, requested the assignment of Lt. Col. Frederick R. Hanson, MC, the psychiatric consultant for the Mediterranean theater, to his office. This assignment brought decided advantages. Colonel Hanson had had considerable combat psychiatric experience, and his opinions were highly respected. He attended the staff meetings of the division in order to keep in touch with developments as they occurred and, then, would be able to relay immediately to the Neuropsychiatry Consultants Division staff information concerning G–1 policies and activities that were psychiatrically significant.

MILITARY INTELLIGENCE DIVISION, G–2

Because of the nature of the activities of G–2, much of the contacts were confidential or secret, and many were not set down in writing. The personnel of the Neuropsychiatry Consultants Division, in cooperation with G–2, assisted in the interviews and coaching of individuals concerned with certain operations for special secret assignments. They also conducted, in the Zone of Interior and abroad, numerous surveys revolving around factors that influenced morale or contributed to psychiatric casualty formation. Information obtained from such surveys and from ETMD (Essential Technical Medical Data) reports concerning the effects of climate, exhaustion, monotony of food, length of service in isolated posts, types of duty, and lack of relief and furloughs; attitudes toward the enemy, their propaganda, prisoners, and ideals; attitudes toward the USO and Army publications; and fear of enemy weapons, such as the 88's, were relayed to G–2. Therefore, liaison was maintained throughout the war.

TRAINING DIVISION, G–3

Some of the most important contacts with G–3 were concerned with pointing out the various factors involved in mental health and their rela-

[18] Farrell, M. J., and Appel, J. W.: Current Trends in Military Neuropsychiatry. Am. J. Psychiat. 101: 12–19, July 1944.

tionship to motivation, morale, leadership, and training. One such communication [19] stated:

> It is believed that a basic underlying cause for the high rate of neuropsychiatric disorders is the inadequate motivation of the average soldier for warfare. It is well established that there is a widespread lack of personal conviction among military personnel as to the issues involved in this war. Large numbers of both officers and enlisted men still do not realize what personal harm the enemy has done, is able to do and intends to do to them and their families. As a consequence, they lack the resolve and determination necessary to withstand regimentation, separation from home, exhaustion and danger of death or mutilation.

It then mentioned other contributing and related causes, among them, "inadequate training." This memorandum was particularly important in the evolution and publication of War Department Technical Bulletins (TB MED's) 12 and 21 which became instruments of orientation and training of officers and enlisted men and were designed to prevent or diminish psychiatric breakdown. The memorandum further stressed command responsibility, pointing out "the problems of mental health are the problems of morale—and morale is a problem of leadership," and it offered psychiatric assistance with these problems.

HEADQUARTERS, ARMY SERVICE FORCES

Basic Conflict

As stated earlier, psychiatry was not only a medical specialty concerned with the prevention and treatment of sick soldiers but was also concerned with the major source of manpower loss which confronted the War Department. Consequently, The Surgeon General was under constant pressure to implement policies and procedures for which the Medical Department no longer had primary responsibility because of the War Department reorganization of 9 March 1942.[20] This produced highly involved and prolonged negotiations throughout the war between the Army Service Forces and The Surgeon General and has been well told in the references cited and need not be repeated here. The reorganization of 9 March 1942 took away from The Surgeon General the powers of classification, assignment, and promotion of medical personnel, as well as the authority to determine policies and procedures relative to hospitalization and discharge of patients. The prerogatives were given to the General Staff, AGF (Army Ground Forces); to Headquarters, AAF (Army Air

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[19] Memorandum, Lt. Col. William C. Menninger, MC, Chief, Neuropsychiatry Division, Surgeon General's Office, for Maj. Gen. Ray E. Porter, G–3, undated, subject: Mental Health of Military Personnel.

[20] (1) Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956. (2) Millett, John D.: The Organization and Role of the Army Service Forces. United States Army in World War II. The Army Service Forces. Washington: U.S. Government Printing Office, 1954. (3) Cline, Ray S.: Washington Command Post: The Operations Division. United States Army in World War II. The War Department. Washington: U.S. Government Printing Office, 1951.

Forces); and to Headquarters, ASF (Army Service Forces). It must be remembered, however, that this action, relieving The Surgeon General of his traditional functions, occurred during the dreadful days following Pearl Harbor, when vigorous efforts were required to make the Army combat ready.

It is noteworthy that a highly qualified and judicial historian of the Army Service Forces, John D. Millett, now (1966) president of Miami University, Oxford, Ohio, finally came to the opinion which was shared by other highly placed ASF staff members; that is, that the Medical Department should have been given more self-determination. "This conclusion seemed to be the prevailing one among ASF organizational planners as World War II came to an end." [21]

Officer Assignments

To illustrate the nature of the problem which complicated the position of The Surgeon General and of other technical service chiefs, two of the serious topics will be mentioned here.

Incompetent officers.—One was the quality of the officers. "The service commands tended to be the dumping ground for all the field grade officers whom the Army Ground Forces found unsatisfactory. This produced a difficult personnel situation and helped to explain why some of the technical services and perhaps even the Army Air Forces distrusted the service commands. Lt. Gen. Brehon B. Somervell and the commanders of the service commands could only make the best of a troublesome situation." [22] The problem of separating incompetent officers, especially those of field grade, was never solved. It was, however, the source of some of the dissatisfactions which eventually manifested themselves in the discharge rate because of low morale.[23]

Malutilization of specialists.—Another important complication was the method of assignment of officers. In a study made by Maj. Gen. Frederick H. Osborn, there is an examination of the Army tradition—

> deliberately overstated for the purpose of emphasis, that all Army officers are interchangeable units, each of whom can be given on-the-job training within the Army which will fit him for any Staff or command function. * * * The theory that a good artilleryman or regimental commander will, with proper seasoning, make an equally good G–1 or G–2, runs counter to the policy and practice of other large scale enterprises whose success can be and is measured by their ability to operate at a profit. Adjustment to modern conditions of war requires that the Army recognize the specialized

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[21] Millett, *op. cit.*, p. 329.

[22] *Ibid.*, p. 371.

[23] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 516–536. (This discusses some needed changes in the Army including officer-enlisted man relationships (Doolittle Board); the method of assignment of officers (Osborn Report); civilian attitudes toward the Regular Army, Regular Army attitudes toward civilians; officer selection, promotion, isolationism, and personnel policies.)

nature of the work to be performed by many of its top staff officers and offer thorough training in universities and in industry to the men slated to fill these positions.[24]

Inherent in the recognition of the need for specialists in this statement was support for senior medical consultants who were only slowly accepted by line officers.

Malutilization of medical officers.—To more than 75 percent of the 2,400 psychiatrists in the Army who looked to The Surgeon General for leadership, but who were under the direction of the service commands, the issue of decentralization was not explained. To them as well as to many other medical officers in the Zone of Interior, it was clear that they were at a disadvantage in regard to assignment, promotion, and caseload distribution. Until 1944, most medical officers in service commands were also handicapped in their professional and administrative duties because of the lack of good communication with the Surgeon General's Office with regard to policy indoctrination, interpretation of regulations and directives, training, and the initiation of new methods as they evolved in the Office of The Surgeon General to meet contingencies.

It is a curious commentary that line officers utilized technical experts, often civilian, to help them in the ceaseless fight to keep ahead of the enemy in such areas as radar and the detection of submarines. They were reluctant to accept the same thesis in the medical and surgical area and, especially so, in the psychiatric area. Until late 1943, it was obvious that as many men were being discharged from the Army as were being inducted and that among the inductees were men of poorer quality than those being discharged.[25]

Medical Policies and Command

Most medical officers and psychiatrists were only too well aware that discharge policy was largely determined at command levels by line officers rather than by the use of medical criteria. They were also aware of the effect of easy discharge upon the morale of other military personnel. However, most medical officers were willing to be good soldiers, so that they followed the directives to the best of their ability. Since there were many and frequent changes and inconsistencies, it was not easy to know, at the time of such changes, the intent of command relative to medical or administrative discharges, until service command headquarters furnished definite instructions.

The psychiatrists were especially under pressure by troop commanders to help in the discharge or transfer of ineffective soldiers. In spite of numerous, but weak-voiced, official statements to the contrary, it seemed

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[24] Report, Maj. Gen. Frederick H. Osborn, Director of Information and Education Division, to Chief of Staff, 16 Nov. 1945, subject: Observations on Army Policy and on the Training of Civilian Reserves.

[25] Ginzberg, Eli, *et al.*: The Ineffective Soldier: The Lost Division. New York: Columbia University Press, 1959, pp. 72–87.

as if Army Service Forces were committed to the thesis that the manpower pool was unlimited and that induction stations would continue to provide a sufficient number of good soldiers to fight the war. Therefore, Army Service Forces, in effect, encouraged medical (certificate of disability for discharge) and administrative (sec. VIII, AR 615–360) discharges until the unexpected magnitude of the number separated from the service forced a change in policy.

The effect of WD Circular No. 161, issued on 14 July 1943, was perhaps the best example of how line officers controlled separation policy. When the number of men released became alarming, WD Circular No. 293, issued on 11 November 1943, rescinded WD Circular No. 161 and, thus, slowed down the separation rate. However, medical officers, particularly psychiatrists, were blamed for misusing psychiatric diagnoses or causing soldiers to be neurotic when the number of men separated on psychiatric grounds increased from 4,000 to about 18,000 monthly. The Inspector General's report of 17 December 1944, after a thorough review in both the Zone of Interior and oversea theaters, absolved the psychiatrists of blame and placed responsibility upon command (pp. 103–105). Brig. Gen. Elliot D. Cooke, a line officer, member of the Inspector General's team which investigated this problem, was encouraged by command to publish his lively and informative findings.[26] After the war, Gen. Dwight D. Eisenhower and General Snyder were sufficiently concerned with the overall manpower utilization problem to encourage a long-term analysis of the induction, selection, and separation policies of the Army by Prof. Eli Ginzberg and his associates, which appeared in three volumes and is a valuable review.[27] Brig. Gen. William C. Menninger [28] has also written an excellent account of these and related problems.

The most important contact concerning separation policy between the Neuropsychiatry Division and Headquarters, ASF, occurred in the summer of 1943. It was not until then that any reliable statistics were available concerning psychiatric casualty rates; therefore, up to that time, there had been no idea of the magnitude of the problem. When the figures were available, a letter with recommendations was forwarded to the Commanding General, ASF.[29]

This letter gave some supporting data and some of the limited statistics available at that time to show that the incidence of neuropsychiatric casualties was greater than anticipated. It then recapitulated all that the Neuropsychiatry Division had accomplished or was attempting to do. It

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[26] Cooke, Elliot D.: All But Me and Thee. Psychiatry at the Foxhole Level. Washington: Infantry Journal Press, 1946.

[27] (1) Ginzberg, Eli, *et al.*: The Ineffective Soldier: The Lost Divisions; Patterns of Performance; Breakdown and Recovery. New York: Columbia University Press, 1959. (2) Ginzberg, Eli, *et al.*: Psychiatry and Military Manpower Policy. New York: King's Crown Press, 1953.

[28] Menninger, *op. cit.*

[29] Letter, Col. John A. Rogers, MC, Executive Officer, Surgeon General's Office, to The Commanding General, Army Service Forces, Washington, D.C., 6 Aug. 1943, subject: Deficient Mental Toughness of Military Personnel.

stressed the necessity for development of mental toughness and preventive psychiatry. A similar letter, omitting the progress made by the Neuropsychiatry Division, was sent to the Acting Chief of Staff on 11 August 1943.

Although attempts to follow up this letter were made, no action was taken as far as the Neuropsychiatry Consultants Division could learn other than the dispatch of the following letter, shortly after 6 August 1943 to all medical officers: [30]

1. In spite of the fact that a much higher percentage of unstable men have been kept out of the Army by induction screening, reports indicate that, nevertheless, the number of men developing nervous and mental breakdowns in combat is considerably greater than it was in the last war. There is increasing evidence that military personnel still do not have the full realization of the issues involved in this war which is needed to develop the mental toughness necessary to withstand separation from home, regimentation, and the physical dangers involved.

2. Medical officers are reminded of their responsibility for the mental as well as the physical health of military personnel. Wherever possible they will assist commanding officers in developing and maintaining a healthy attitude in mind in the command.

3. The specific goals to be attained are that each soldier:

a. Feels he has a reason to fight worthy of the sacrifices involved; whether this is to protect his family, to save his country, to preserve his way of life, will depend upon the individual soldier.

b. Feels angry at the enemy; most soldiers are more aware of what the Japanese have done to him than what the Germans have done or threaten to do.

c. Fears not fighting, fears the consequences of defeat, fears what his buddies will say if he doesn't do his share.

d. Has confidence in himself—in his ability to fight, his weapons, his skill, his strength, his importance.

e. Has confidence in his outfit, his country, his Allies—confidence that they will do their part if he does his, that they are backing him up.

f. Confidence in his leaders—confidence in his leader's ability and in his leader's own willingness to sacrifice himself for their common goal.

BY ORDER OF THE SECRETARY OF WAR:

J. A. Ulio,
Major General,
The Adjutant General.

MILITARY TRAINING DIVISION, ARMY SERVICE FORCES

From January 1944, the Neuropsychiatry Consultants Division enjoyed fairly close liaison with the Military Training Division of the Army Service Forces. Previous to that time, contacts were meager and incidental. Good relationships were established particularly through Maj. Samuel Goldberg, MC, who attended the Neuropsychiatry Consultants Division staff conferences usually once a week. Some of the more important liaison efforts were in connection with replacement training centers of the Army Service Forces, psychiatric films, and directives on the psychiatric aspects of training, especially TB MED's 12 and 21.

[30] Letter, The Adjutant General, to All Medical Officers, August 1943, subject: Deficient Mental Toughness of Military Personnel.

Joint experimental study.—The most important contact with the Military Training Division was in the joint experimental study concerning efforts to salvage psychoneurotic patients. The War Department and the Medical Department were considerably alarmed at the large loss in manpower resulting from psychoneurosis. As a result, the policy of the Army had changed from one of discharge for psychiatric patients to one of salvage, if possible. Accordingly, on 18 January 1944, Colonel Menninger forwarded the following memorandum to Brig. Gen. Charles C. Hillman, MC, Chief, Professional Service, Surgeon General's Office:

1. What are we going to do to attempt salvage of the psychoneurotic at the level of the large station hospital and general hospital? General Kirk's letter states that where men can be salvaged at that level, they should be. *But*: (1) The present attitude in all station hospitals is to move the men as fast as possible; (2) there has never been a directive about any treatment plan for psychoneurotic patients (except in the theater of operations); and (3) to keep them in the hospital with the present physical setup for any kind of psychiatric treatment is probably detrimental.

2. Our suggestions for an attempted solution of the problems are:

(1) Follow up this directive recommended by General Kirk with a letter from The Surgeon General to hospital psychiatrists to initiate treatment on the salvageable cases.

(2) Utilize barracks adjacent to the hospital for housing. If these are not available, convert one or as many as necessary, open (W–1) wards into barracks as rehabilitation quarters for the psychoneurotic (and perhaps other limited service) patients.

(3) Develop a rehabilitation program in accordance with their capabilities, with as much military aspect as we can, and utilize occupation, education, and recreation. The psychiatrist can spend an hour or two, or whatever time is necessary, with his acute hospital cases—the rest of his time directing his program.

3. Results of such a plan, I believe, would be:

(1) We would begin putting some emphasis on treatment at an earlier stage. In this connection, I think, from the psychiatric viewpoint, the weakness of the plan in sending men to retraining centers is that these men in hospitals do not need retraining; they need psychiatric treatment.

(2) If a barracks is utilized, this plan would free a considerable number of beds in the hospital, yet the whole procedure would be as it should be: a medically directed program.

(3) In general, it could be set up in existing installations requiring no additional psychiatrists, and most of the psychoneurotic patients presently held in the wards would be in this rehabilitation barracks.

(4) It is an extremely important point that a soldier, breaking in the Army, has his optimum chance for rehabilitation while *still in the Army*. Many of those discharged and sent home are looked upon with doubts and suspicion, are often refused jobs, become pension seekers, and are no good to themselves. Not only for manpower salvage but for the over-all good to the man and society, strenuous efforts should be made at treatment and rehabilitation. It is my belief that this is the most vulnerable point for possible criticism of the Medical Department of the Army.

4. This plan presupposes that there can be a major change in the opportunities for reclassification and reassignment.

5. An improvement even in this tentative plan would be to develop good out-patient clinics in our larger posts with neuropsychiatry being represented in the clinic. In this manner we would catch the failing soldier even at an earlier stage and he could

be worked up in the clinic and sent to the psychiatric rehabilitation program in the hospital directly without ever actually being in the hospital. At most of our installations we do not have adequate out-patient clinics but I believe this would apply to all fields of medicine.

Since the function of putting a salvage project into effect involved the Army Service Forces headquarters, request was made for a meeting to discuss preliminary plans. Such a meeting was held on 23 January 1944,[31] and it was tentatively planned to establish pilot, experimental replacement training centers at Fort Belvoir, Va., Aberdeen Proving Ground, Md., and Camp Lee, Va. These locations were selected because their proximity to Washington would permit easy accessibility for more careful and closer supervision.

Since the training center at Aberdeen was under the Chief of Ordnance, the one at Camp Lee under the Quartermaster General, and that at Fort Belvoir under the Military District of Washington, a meeting of the representatives of those offices was held on 27 January 1944, in order to acquaint them with the plans. A report[32] of this conference by Colonel Menninger stated, in part, as follows:

* * * the tentative plan for the establishment of these units, setting forth the course the patient follows from the hospital, through a screening and classification group, Camp Lee, at which point they will be distributed to the units under the replacement training centers at Lee, Belvoir, and Aberdeen. Each of these three replacement training centers were given an allotment of 50 out of their total unit of 420 men to be filled from similar patients discovered by replacement training center psychiatrists in these installations. The remaining number in each group, 370, will come from the hospitals. One company of Negroes will be established at Camp Lee. Because of housing problems, these will not be called for until approximately the 1st of March.

* * * a team of psychiatrists, classification officer, personnel consultant, and training officers from each center will constitute the screening board at Camp Lee. Once the man arrives at his particular unit, a board consisting of the battalion commanding officer, classification officer, a psychiatrist, personnel consultant, and training officer will plan and execute the program, and are to be free to change the course for an individual man at any time, and will recommend assignment whenever the man has obtained satisfactory proficiency. It was agreed that a man might be competent and able to fit into one of the regularly established courses for the replacement training center students and when this was possible, such should be done. Furthermore, it was assumed that a transfer might be made between centers in order to avail a man of the opportunity to have a different type of training.

Most of the units did not feel that additional equipment would be necessary. It is tentatively planned to start the screening at Camp Lee on February 7th. On February 2nd at 2:00 p.m. another conference is to be called and is to be attended by the battalion commanders, classification officers, psychiatrist, personnel consultants, and training officers involved.

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[31] Memorandum, Chief, Neuropsychiatry Division, the Surgeon General's Office, to Chief of Professional Services, the Surgeon General's Office, Washington, D.C., 23 Jan. 1944, subject: Conference Regarding Plans for Retraining Centers in Replacement Training Centers for Neuropsychiatric Patients and Returned Oversea Soldiers.

[32] Memorandum, Chief, Neuropsychiatry Division, the Surgeon General's Office, to Chief of Professional Services, the Surgeon General's Office, Washington, D.C., 27 Jan. 1944, subject: Conference Regarding Establishment of Retraining Centers in Replacement Training Centers for Psychoneurotics.

To avoid loss of time and pending the publication of orders, an airmail letter [33] containing instructions was dispatched to the four service commands which were to supply the trainees. Within a week, this letter was implemented by ASF Circular No. 40,[34] giving authority and direction for the operation of the units, pertinent extracts of which are as follows:

II—TRAINING—1. Developmental training units (experimental) are hereby established at the Quartermaster Replacement Training Center, Camp Lee, Virginia, the Engineer Replacement Training Center, Fort Belvoir, Virginia, and the Ordnance Replacement Training Center, Aberdeen Proving Ground, Maryland, effective 7 February 1944, with a capacity of 500 each.

2. *Mission.*—The mission of these units is to determine the feasibility of conserving manpower by the training or retraining under existing training doctrine and instruction methods of individuals (male) who, due to psychoneurotic illnesses, are—

a. Unusable in the capacity for which trained, and/or

b. Of limited military value.

3. *Personnel to be trained.*—*a.* Personnel at general hospitals for whom there seems to be a reasonable chance of rehabilitation through reclassification and individual training in special fields.

b. Personnel presently at the three replacement training centers referred to in paragraph 1 who cannot meet the requirements of either POR [preparation of replacements for oversea movement] of POM [preparation for oversea movement (units)] due to psychoneurotic illness.

4. *Method of selection.*—Personnel selected for retraining in these developmental training units will not be sent if their illnesses are so severe as to make them definitely of no further value to the service.

a. Selection will be made from general hospitals in accordance with letter SPMDU, subject, "Retraining for the Psychoneurotic Patient," 28 January 1944.

b. From the replacement training centers enumerated in paragraph 1 by the respective replacement training center commanders.

5. *Transfer procedure.*—*a.* Allotments will be published by the Adjutant General upon recommendation of the Military Training Division, ASF, to the Second, Third, Fourth, and Fifth Service Commands, and to the respective replacement training centers.

b. Only one allotment of personnel will be published for this experiment.

c. Men recommended by the general hospitals within allotments for this training will be reported by TWX to the Adjutant General's Office (Classification and Replacement Branch), SPXOC-H.

d. The Adjutant General will reply to hospitals by TWX indicating the number of men to be shipped and specifying the desired date of arrival at Camp Lee, Virginia.

e. Personnel so transferred will be discharged from the hospital, returned to duty status, and ordered to report to the commanding officer of the Special Classification Group, Camp Lee, Virginia.

f. Transfer to and from these developmental training units will normally be in grade.

g. The hospital will forward an abstract of the soldier's medical history and such other data and remarks as will aid the Special Classification Group to evaluate personnel adequately.

h. The Adjutant General will coordinate the flow to the Special Classification

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[33] Letter, War Department, Services of Supply, Office of The Surgeon General, to The Commanding Generals, Second, Third, Fourth, and Fifth Service Commands (attention: The Surgeon), 28 Jan. 1944, subject: Retraining for the Psychoneurotic Patient.

[34] Army Service Forces Circular No. 40, 5 Feb. 1944.

Group from hospitals so as to provide not to exceed 80 men per day until capacities of developmental training units are reached.

6. *Special Classification Group.—a.* For the purpose of properly classifying personnel from hospitals, a Special Classification Group is established at Camp Lee, Virginia.

b. The Special Classification Group will analyze all personnel ordered from general hospitals, determine the initial training which they will pursue, and ship them to one of the three centers indicated in paragraph 1.

c. Upon completion of its mission, the Special Classification Group will be disbanded.

7. *Organization of each training unit.*—An additional overhead allotment to the appropriate agencies will be made by the Military Personnel Division, ASF, for the period of the experiment.

8. *Training.—a.* Basic military training will be limited to the capabilities of the individual. It will not include all-night bivouacs or training requiring exertion beyond the capabilities of the group generally. Where desirable, training scheduled will be alternated between the two companies to provide in each company one-half day of technical training and one-half day of basic military training, organized athletics, and time for personnel and medical consultation.

b. It is desired that each center develop the training independently to determine the rapidity with which this personnel can be trained. Detailed records of the training accomplishment of all individuals will be maintained so that the conclusion of the training, the degree of effectiveness of this program, and the feasibility of its continuation can be determined.

9. *Transfer of personnel from developmental training units.—a.* Personnel will be reported to the Adjutant General for assignment as individuals when in the opinion of a board consisting of the battalion commander, the psychiatrist, and the personnel consultant, the individual is prepared for return to duty.

b. Personnel will be reported to the Adjutant General for transfer under classification numbers indicated by the board mentioned above.

c. Personnel incapable of completing any course of training in the subject installations will be discharged under section II or section VIII, AR 615-360, as applicable.

The experiments continued for a period of about 3 months, the operations of which are summarized from a report made by Lt. Col. William H. Everts, MC, who was the representative of the Neuropsychiatry Consultants Division.

1. c. Of this experimental group of 1,253 men, 880 (70%) were made available for limited assignment for the Zone of Interior in noncombatant units. This availability was determined upon the recovery which took place under controlled conditions in the training units and is not an indication of performance under conditions not similarly controlled. Of the remaining not reclaimed for military duty, the majority were benefited by this program prior to discharge from the service.

d. This was accomplished at a cost of 62 officers and 250 enlisted cadre, a 20% overhead for total personnel or a 26% overhead for salvaged personnel. This is exclusive of the special classification group which is referred to in paragraph 2 a. below.

e. All troops in this experiment were white with exception of one company which was colored.

2. Screening—

a. The problem of screening was one of considerable magnitude since approximately one thousand (1,000) of these troops were hospitalized personnel with neurotic illness from both overseas and continental organizations. The troops were heterogeneous as to major force, age, AGCT group and degree of emotional instability. This

problem was met by an initial medical screening at the hospital and subsequently by a special classification group screening at Camp Lee, Virginia, where the emotional, physical, and occupational suitability for retraining was determined and allocation to the appropriate training centers was conducted.

b. All white personnel was equitably distributed to the three Army Service Forces Training Centers according to the above factors. In addition, each of the three training centers screened and supplied fifty (50) individuals through their own mental hygiene clinics.

c. The troops of the colored company which were trained only at Camp Lee, Va., received the usual screening at the hospital and subsequently by the battalion classification group at Camp Lee.

3. Contributory Problems—

Administrative problems evidenced in these trainees which needed and were given immediate attention included furlough, lack of pay and family allotments, clothing and equipment shortages, assignment discontent, unwarranted promises, and incomplete or lost military records. Correction of the above matters produced a prompt improvement in morale and aided materially in the acceptance of their responsibilities as soldiers. In addition, prolonged or repeated hospitalization through medical echelons had contributed to the chronicity of their disability.

4. Operation of Units—

The Developmental Training Units of each camp were voluntarily set up in accordance with their own physical and administrative dictates.

a. The Unit at Aberdeen Proving Ground, Maryland, [Lt. Col. R. Robert Cohen, MC, Chief of Neuropsychiatry Service] was designated and operated as a separate battalion, under the direct control of the Commanding General, ASFTC. The battalion operated its own Personnel and Classification Sections. This direct access to vital records was essential to prompt and efficient solution of problems which were definite morale factors: pay, furloughs, allotments, decorations, and assignments. The condition of records received justifies the need of immediate battalion supervision. All military and technical training and recreational activities functioned under direct battalion control, with existing post agencies and schools providing technical training facilities.

b. The Fort Belvoir Unit [Maj. Bernard A. Cruvant, MC, Chief of Neuropsychiatry Service] operated as a semi-isolated separate battalion, responsible directly to the Commanding Officer of the Army Service Forces Training Center. Technical training was supplied by existing post agencies, offices, and schools, in accordance with the recommendations of the Development Training Unit. Military training and recreational activities were conducted directly by the units. The battalion also operated and possessed its own consultation service, classification section, dispensary, recreation hall, company day rooms, mess halls, post exchange and chapel. Officers and enlisted cadre were quartered within the unit area.

c. The Unit at Camp Lee [Maj. Fred F. Senerchia, Jr., Chief of Neuropsychiatry Service] was designated as a part of and was physically located within a training regiment. Rations, quarters, and administration were under regimental control, whereas the application of training doctrines and function as well as disposition of the trainees was entirely under battalion control.

d. Though all three battalions functioned effectively and efficiently, experience indicates that, for the best interests of the trainees themselves and of the other troops of the camp, a battalion of a semi-isolated, separate type is more desirable.

e. Experience further dictates that colored developmental units should have a colored cadre and be maintained with other colored organizations.

5. Results—

There was a total of 880 (70%) troops retrained to an assignable level. Of the

white troops, 805 (or 72%) and of the colored troops, 75 (or 52%) were retrained and made available for assignment.

6. Operating Overhead—

a. Actual operations required 62 officers and 250 enlisted cadre for the three experimental units (1253 trainees).

b. Experience gained during the progress of the experiment indicated that a more efficient organization would consist of a Battalion Headquarters of eleven (11) officers and 29 enlisted cadre; and companies of 6 officers and 30 enlisted cadre. On this basis, three two-company battalions as used in the experiment would have required 69 officers, 267 enlisted cadre for 1320 trainees. This slight increase in overhead would be necessary for continuous functioning. The suggested battalion headquarters would be capable of administering up to 6 companies of 220 men each.

7. Conclusions—

Experimental Units have retrained the personnel as stipulated in Section II, ASF Circular No. 40. Graduates have been reported to the Adjutant General for proper assignment. A definite determination of their usability must, however, be based upon the 30-day performance ratings submitted by the organizations to which assigned for duty.[35]

The Neuropsychiatry Consultants Division considered that these experiments were highly successful. However, in spite of repeated recommendations of the director that the experiments be continued, ASF headquarters refused permission to continue, on the grounds that there was already an oversupply of limited-service personnel available for reassignment.[36] In fact, just as it was being demonstrated that many soldiers could be used in limited-service categories, the War Department, because of the oversupply, published two new sweeping directives aimed at separating these men as expeditiously as possible, by either medical or administrative means for "the convenience of the Government." [37]

Thus, it can be seen that the struggle to retain marginal manpower as seen in these units came to naught. While it could be demonstrated in these special training units that approximately 70 percent of previous noneffective personnel, mainly those ineffective for psychological reasons, could be placed on a limited type of duty, the central problem was the cost of this training and the limited need for this type of personnel. From a humanitarian standpoint, it was no doubt better to proceed from Colonel Menninger's idea [38] to help these people regain their self-esteem and not discharge them as psychoneurotics. Indeed, not only humanitarian considerations were involved, since most of these men, if untreated, were almost certain to become pensioners of the Federal Government. Yet, this was wartime and the other side of the question had to be considered. The hard facts were

[35] As far as can be determined, no followup study of performance was ever accomplished.—A. J. G.

[36] (1) Memorandum, Director, Neuropsychiatry Division, for Director, Military Personnel Division, ASF, Washington, D.C., 29 July 1944, subject: Establishment of Separate Training Battalion. (2) Memorandum, Director, Military Personnel Division, ASF, for The Surgeon General, Washington, D.C., 5 Aug. 1944, subject: Retraining of Soldiers Previously Disabled by Psychoneurotic Disorders. (3) Memorandum, Director, Neuropsychiatry Division, Surgeon General's Office, for Director, Military Personnel Division, ASF, Washington, D.C., 10 Aug. 1944, subject: Retraining of Soldiers Previously Disabled by Psychoneurotic Disorders.

[37] (1) See footnote 25, p. 111. (2) Army Regulations No. 615–360, 26 Nov. 1942.

[38] See footnote 37 (2) above.

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that well-trained personnel required to train such ineffective personnel were a scarce category. More pertinent still was the fact that the country was surfeited with individuals with mental or physical defects who could only be assigned positions in the continental United States. Indeed, as stated by the Military Personnel Division, ASF,[39] this glut of limited-service personnel would make impossible the further assignment of personnel who would complete such special training.

The basic error involved was in the too easy acceptance of the limited-personnel category—the prevailing tendency in most of World War II to easy access of hospitalization for minor physical symptoms and verbal complaints of soldiers relative to nervousness, anxiety, and their associated somatic tension states. This was further compounded by the overliberal use of the term "psychoneurosis." The word "psychoneurosis" blinded both the patient and physician and created a climate in which the individual with some degree of honorable acceptance could utilize the subject's state of physical and mental discomfort, situationally induced to avoid the social obligation of a citizen at war. Hospitalization, a priori, conferred status upon their complaints. Easy discharges from the service for psychoneurosis made difficult any effort to motivate other individuals similarly designated to assume any type of duty except that which promised the least degree of stress. Only by a thorough change in attitude of both line and medical officers to this typical wartime phenomena could there be produced a significant change in the climate under which war must be fought and that unhappiness and discomfort are not disease, and one must carry on despite their presence.

INFORMATION AND EDUCATION DIVISION, ARMY SERVICE FORCES

With the transfer of Lt. (later Maj.) John W. Appel, MC, to the Neuropsychiatry Branch, early in 1943, for the purpose of instituting a program of preventive psychiatry, it was considered essential that a close liaison exist between the Information and Education Division, ASF, then known as the Special Service Division, which was charged with the moral program of the Army.

As time went on, this liaison was developed to a remarkable degree. Full consideration of the developments are discussed in chapter XIV, "Preventive Psychiatry."

A most important joint effort between the two offices was the evolution of a paper-and-pencil test known as the NSA (Neuropsychiatric Screening Adjunct).[40] Induction stations began using this test on 1 October 1944. The test was designed to identify inductees who were in need of further

[39] See footnote 25, p. 111.

[40] War Department Memorandum No. 40–44, 19 Sept. 1944.

psychiatric examination. Thus, where few qualified psychiatrists were on duty, psychiatric examination could be reserved mainly for men so screened by the test. Where sufficient psychiatrists were present, all inductees were given a psychiatric examination. Although considerable effort was directed toward correlating the validity of NSA, the war ended before the data could be evaluated. (See also pp. 185–188.)

HEADQUARTERS, ARMY GROUND FORCES

The liaison with the Army Ground Forces was not successful until late in the military effort. The first contact occurred during 1942 when attempts were made to assign neuropsychiatrists to combat divisions. The Ground Forces were bitterly opposed to such a move, and it was not until The Surgeon General himself forced the issue at War Department level that the recommendation was approved. The personnel of the Army Ground Surgeon's Office were not psychiatrically oriented, and although friendly, they regarded with suspicion all projects presented by the Neuropsychiatry Consultants Division. They did not favor the elevation of the Army psychiatric consultant to the same rank held by the medical and the surgical consultants. They were opposed to the division psychiatrist's being on the division surgeon's staff, but favored his placement in the clearing company. Many more conferences were required with Headquarters, Army Ground Forces, than with any other agency when approval was required for neuropsychiatric directives.

Maj. Alfred O. Ludwig, MC, Consultant in Neuropsychiatry for the Seventh U.S. Army, was appointed to the Office of the Army Ground Surgeon in August 1945. From then on, liaison was very close. Major Ludwig attended the Neuropsychiatric Consultants Division staff meetings regularly, to the mutual benefits of both offices.

HEADQUARTERS, ARMY AIR FORCES

Good personal relationships were maintained with the psychiatrists assigned to the Air Surgeon's Office, even though that office operated more or less independently of the Surgeon General's Office, particularly in matters relating to aviation medicine. Maj. (later Lt. Col.) John M. Murray, MC, was assigned late in 1942 as the chief psychiatrist in the Air Surgeon's Office. Frequent consultations were held between the neuropsychiatric elements of both offices, and when Lt. Col. Donald Hastings, MC, succeeded Colonel Murray on 13 October 1944, the same relationship continued. Colonel Hastings was also a frequent visitor to the Neuropsychiatry Consultants Division and its staff meetings. This close liaison was continued with Maj. Douglas D. Bond, MC, who succeeded Colonel Hastings, in August 1945.

LIAISON WITH OTHER DIVISIONS, SURGEON GENERAL'S OFFICE

There was always a close relationship between neuropsychiatry and the other major branches of medicine in the Surgeon General's Office. An understanding of psychological factors in physical diseases and the reverse was fostered. Relationships were especially close with the Medical Consultants Division, whose members were very sympathetic and understanding in psychiatric problems. Officers of the two divisions frequently collaborated in special projects. The first meeting of the service command consultants, on 25 and 26 October 1943, was a combined meeting attended by both medical and neuropsychiatric consultants (fig. 24). In subsequent meetings of either division, the representatives of the other were invited to attend so that mutual problems might be discussed and all might be aware of developments.

Close liaison was enjoyed with the Physical Standards Division. Matters of induction standards and criteria for discharge were freely discussed, the recommendations of this division being sought and accepted in such matters.

Close cooperation with the Personnel Division resulted in the proper

FIGURE 24.—Conference in the Surgeon General's Office after V–E Day, on development of medical facilities in the Pacific. Left to right, seated: Brig. Gen. Thomas D. Hurley; Brig. Gen. Hugh J. Morgan; Col. John E. Gordon, MC; Lt. Col. Perry C. Talkington, MC; Brig. Gen. William A. Hagins; Dr. Eli Ginzberg; Col. William C. Menninger, MC; Brig. Gen. Raymond W. Bliss; Brig. Gen. Guy B. Denit; Maj. Gen. Norman T. Kirk; Brig. Gen. John M. Willis; Brig. Gen. Joseph I. Martin; Maj. Alfred O. Ludwig, MC; Lt. Col. Frederick R. Hanson, MC; Col. William S. Middleton, MC; Col. Maurice C. Pincoffs, MC; Col. Christian B. Pederson, MC. Left to right, standing: Col. Frederick B. Westervelt, MC; Col. Leonard D. Heaton, MC; Capt. Gilbert W. Beebe, MAC; Col. Durward G. Hall, MC; Col. Albert H. Schwichtenberg, MC; Col. Benjamin M. Baker, MC; Col. George G. Finney, MC; Col. S. Alan Challman, MC; Col. Isaac R. Trimble, MC; Col. Charles B. Odom, MC; Maj. Gen. George F. Lull; Lt. Col. Norman Q. Brill, MC; Col. Augustus Thorndike, MC; Lt. Col. Robert J. Moorhead, MC; Lt. Col. Lamar C. Bovil, MC; Lt. Col. William G. Srodes, MC; Col. Lloyd J. Thompson, MC; Brig. Gen. Earl Maxwell; Brig. Gen. Charles R. Glenn; Lt. Col. Thomas McGibony, MC; Col. Kermit H. Gates, MC; Col. John B. Klopp, MC.

placement of psychiatrists who were assigned out of their specialties. All major and most of the minor transfers and special appointments of neuropsychiatric personnel were made after discussion with the Neuropsychiatry Division and according to its recommendations.

The Neuropsychiatry Division maintained close liaison with the Hospital Division. The many questions of policy relating to treatment and evacuation required a major portion of the time of the representatives of the neuropsychiatric office. The Hospital Division had representatives at all major conferences on psychiatric matters. Space does not permit even a synopsis of the numerous problems which constantly had to be met because of changes in the military and administrative setting. Fortunately, there are excellent accounts of the major issues described by Smith, Armfield, and Menninger.[41] As mentioned earlier, the volumes by Millett, Cline, and McMinn and Levin [42] are useful correlative references in order to gain a better insight into the total manpower problem as well as the operational difficulties facing The Surgeon General.

The Director of the Neuropsychiatry Division made a practice of summarizing the psychiatric problem, particularly for the information of The Surgeon General. One particular letter was significant because it represented a rather complete summary of all aspects of the neuropsychiatric problem as seen through the eyes of Colonel Menninger as of 15 June 1944 (appendix E). In it, one can recognize many changes on previous opinions. It recognized the inadequacy of screening; emphasized the need of treatment; and strongly showed the relationship between morale and the psychiatric case. It pointed out that lax and vacillating manpower policies powerfully affected the rates of discharge of psychiatric administrative reasons.

MISCELLANEOUS, TECHNICAL, AND OTHER AGENCIES

Office of the Inspector General

The contacts of the Neuropsychiatry Consultants Division with the Inspector General's Office were mainly in a professional, advisory capacity in the investigation of special problems. No continuous liaison was maintained. On three occasions, however, officers of this division were placed on temporary duty with that office. First, in January 1944, when the Assistant Director accompanied the representatives of the Inspector General to the Port of Embarkation, Hampton Roads, Va., to supervise the physical examinations of personnel returned from a replacement center in North Africa. Second, on 1 March 1945, when the chief of the Psychiatry

[41] (1) Smith, *op. cit.* (2) Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963, pp. 463–495, 525–538. (3) Menninger, *op. cit.*

[42] (1) Millett, *op. cit.* (2) Cline, *op. cit.* (3) Medical Department, United States Army. Personnel in World War II. Washington: U.S. Government Printing Office, 1963.

Branch accompanied a party from the Inspector General's Office for temporary duty in the Pacific Ocean Areas in connection with the special G–1 study on psychoneurosis. Third, on 29 March 1945, when the chief of the Neurology Branch accompanied a similar party on the same mission to the European and Mediterranean theaters.

Office of the Judge Advocate General

The contact between the Neuropsychiatry Consultants Division and the Office of the Judge Advocate General was, for the most part, on a consultative basis. The majority of the contacts consisted mainly of the reference of legal cases and problems for professional psychiatric opinion. Elsewhere in this volume, there is a complete description of the close liaison established in such problems as disposition of homosexuals, the simplification of commitment laws, and the preparation of TB MED 201, "Psychiatric Testimony Before Courts-Martial," issued on 1 October 1945.

Theaters of Operations

Liaison with the theaters of operations was notably poor early in the war, especially with the Southwest Pacific Area. Oversea theaters were autonomous, and the theater commanders had relatively complete authority within their commands. At first, contacts were extremely meager and, then, only through informal personal communications. Professional consultants in oversea theaters were strictly forbidden to contact the Surgeon General's Office except through formal channels, which made it practically impossible to obtain useful information. Indeed, in the Southwest Pacific Area, the consultants were threatened with banishment to the hinterlands if they transgressed the order.[43] Gradually, however, such practices were eliminated, and it was finally possible to send and receive badly needed professional information.

It was not until late in the military effort that any representative of the Neuropsychiatry Division had the advantage of making a visit to a combat theater to learn its problems at firsthand. Some of the major visits were Major Appel's visit to the Mediterranean theater; Colonel Menninger's to the European theater; and Colonel Farrell's and Major Berlien's to the Southwest Pacific Area.

Bureau of Medicine and Surgery, U.S. Navy

A close and friendly liaison existed between the personnel of the Neuropsychiatry Branch of the Bureau of Medicine and Surgery of the U.S.

[43] Obviously, documentation of this statement was not feasible, but it had been substantiated orally by consultants who served in the theater.—A. J. G.

Navy, especially with Comdr. (later Capt.) Francis J. Braceland, MC, and this division. Information and copies of directives available to one office were continuously made available to the other. Each office was generous in its response to requests for advice on certain problems, and both were able to present united fronts on questions vital to military psychiatry. The directors and other representatives of the two offices often appeared together before congressional committees, at professional meetings, and at meetings in which mutual problems were discussed.

Selective Service System

The Neuropsychiatry Consultants Division always maintained a close liaison with the Selective Service System. Numerous conferences were held between various members of the medical staffs of both organizations. This liaison, while not very effective at first, was made closer when Dr. Raymond W. Waggoner was appointed neuropsychiatric consultant to the Selective Service System, in September 1943. Following his appointment, many difficulties disappeared which, singly, were of little consequence but, collectively, led to major misunderstandings.

One of the most important accomplishments resulting from the unified actions of the two offices was the launching of the Medical Survey Program, in October 1943. A detailed description of this program is contained in chapter VIII, pages 177–185.

American Red Cross

Army Regulations No. 850–75 provided for the American Red Cross to act as a liaison between the Army and civilian agencies for welfare purposes. Since these duties included social work, a close liaison developed between this division and the Office of the Psychiatric Social Work Consultant, particularly Miss Florence Brugger, who occupied the position of consultant from 15 February 1942, until 15 December 1942. Miss Dorothea Schuyler succeeded Miss Brugger, serving until October 1944, and was succeeded by Mrs. Imogene Young.

Through the cooperative efforts of the two offices, psychiatric social workers were recruited by the Red Cross for service in military installations in the Zone of Interior as well as overseas. In addition to assigning psychiatric social workers to general, regional, and station hospitals and, later, to convalescent hospitals, the American Red Cross also provided psychiatric social workers in the consultation services of mental hygiene units. These workers contributed greatly to proper diagnosis, treatment, and disposition. In many instances, they worked in cooperation with military psychiatric social workers. In such cases, the Red Cross workers handled the liaison with the community, while the military workers cared for the situation within the military organization.

Allied Armies

Close liaison was established with the directors of psychiatry in both the British and Canadian Armies (fig. 25). This relationship was firmly established by visits of these individuals to the United States. In the fall of 1943, Brig. John R. Rees, RAMC, Chief Consultant in Psychiatry to the British Army, and Lt. Col. George R. Hargreaves, RAMC, his assistant, visited the Neuropsychiatry Consultants Division on a courtesy tour of inspection (fig. 26) of medical installations in the United States and Canada. Lt. Col. John D. Griffin, RAMC, the Chief Consultant in Psychiatry to the Canadian Army, joined the group of visitors. In addition to conferences with the various members of the Neuropsychiatry Branch, the British and Canadian visitors made personal contacts with other officers in the Surgeon General's Office and the War Department.

FIGURE 25.—Meeting of American, Canadian, and British psychiatrists in Montreal, Canada, 16 November 1943. Left to right, seated: Lt. Col. Malcolm J. Farrell, MC, Brig. John R. Rees, RAMC, Lt. Col. William C. Menninger, MC, Lt. Col. George R. Hargreaves, RAMC. Left to right, standing: Brigadier McGibbon, Brig. Jonathan C. Meakins, Travis E. Dancey, and Lt. Col. John D. Griffin, RAMC.

FIGURE 26.—British and American medical officers, on a tour of inspection of all surrounding hospitals near Atlanta, Ga., attend a general conference in Atlanta, 10 November 1943. Left to right, front row: Brig. John R. Rees, RAMC, Col. Sanford W. French, MC. Left to right, back row: Lt. Col. William C. Menninger, MC, Lt. Col. George R. Hargreaves, RAMC, Col. John D. Griffin, RAMC, and Lt. Col. Malcolm J. Farrell, MC.

On 5 November 1943, the British officers, accompanied by Colonel Farrell, visited medical and psychiatric installations of the Second and Fourth Service Commands, particularly the Engineer Replacement Training Center at Fort Belvoir. They were particularly interested in the basic training infiltration course and in the activities of the psychiatric consultation services.

On 15 November 1943, Colonel Farrell and Colonel Menninger, then Fourth Service Command Consultant in Neuropsychiatry, accompanied Brigadier Rees, Colonel Hargreaves, and Colonel Griffin on a 15-day tour to visit various medical military installations in Canada.

During Colonel Menninger's visit to the European theater in August 1944, this liaison was further cemented by a visit with Brigadier Rees. The director was able to see British military psychiatry function at firsthand.

On 10 November 1944, Brigadier Rees returned to this country for the purpose of delivering the Salmon Memorial Lecture, in New York City,

N.Y. Previous to this, he had the opportunity to visit the Surgeon General's Office and to accompany the director on another visit to Army installations in the Midwest. On 15 November 1944, Brigadier Rees and Colonel Menninger attended the Under Secretary of War's conference on rehabilitation held at the U.S. Disciplinary Barracks at Fort Leavenworth. Both officers presented papers.

As a result of this liaison, information, publications, films, and directives were made available to the psychiatric services of the United States, British, and Canadian Armies. The advantages of such an admirable liaison are self-evident.

Civilian Organizations

It was impossible for members of the Neuropsychiatry Consultants Division to respond to all the requests by civilian organizations for lectures and scientific papers. As might be expected, the greatest number of such contributions were made to organized psychiatric groups. Many papers written by members of the division were published in both professional and lay journals. These were assembled in periodic bibliographies of limited publication through the Surgeon General's Office.

CHAPTER VII

Public Relations

William C. Menninger, M.D.

ABSENCE OF PUBLIC RELATIONS PLANNING

Because of its universal applicability to the everyday life of the everyday man, psychiatry has long been a favorite theme for feature articles in newspapers and magazines. The theme of Mesmer, Émile Coué, and Dale Carnegie have always had an avid consumption by the public. Perhaps on this basis alone, it should have been foreseen that the thoughts and feelings of a "civilian army" would be of major public interest to the folks at home. In addition, however, it was known from the history of World War I that the neuropsychiatric problem would be no small one, either in magnitude or importance. Despite these facts, however, at the onset of World War II, no particular consideration had been given to public relations or public education concerning psychiatry and its implications in the Army. In fact, one can truthfully state that no planning in this direction was made, which in some degree paralleled the lack of planning and the adequate understanding of the inherent psychiatric problems of selection, of placement, of personality adjustment, and of psychiatric battle casualties.

The events that transpired rapidly changed this apathy and indifference to one of great concern. Alarm was expressed relative to the high rate of rejection of men at induction centers because of various types of personality disorders. It was discovered that even in basic training camps the major causes for failure in training and consequent discharge were personality disorders. The figures leaped to such heights that G–2 (intelligence) of the War Department apparently sensed inherent and potential dangers in having such facts widely known. In recognition of the demand for information, the Neuropsychiatry Branch, Professional Service, SGO (Surgeon General's Office), under Col. Roy D. Halloran, MC, on 25 September 1943, prepared the following release which was, however, disapproved by the Bureau of Public Relations of the War Department:

Neuropsychiatric Data for Press Release

Between 8 and 10 percent of men examined at induction have been rejected as being unfit for service because of nervous and mental disorder. In spite of this, the incidence of neuropsychiatric disorder, particularly in combat troops, has been high.

In the Southwest Pacific Area, the admission rate has been in the region of 60 per 1,000 strength per year. In the South Pacific Area, the report states that 25 percent of all admissions have been neuropsychiatric. Twenty percent of casualties suffered

by an Army Corps in the Maknassy-El Guettar battle were neuropsychiatric, and for 3 days, the figure was as high as 33 percent of the total. The vast majority of these cases are anxiety states resulting from extreme exhaustion. In a few days, with prompt sedation and rest, as high as 80 percent of them may return to full combat duty. There is a distinct question as to whether they should even be labeled as "neuropsychiatric" cases, for they are merely the reactions anybody might have if exposed long enough to combat conditions.[1]

In the continental United States, the neuropsychiatric admission rate has shown a steady increase until now at 48 per 1,000 strength per year for the month of August 1943, it is over 6 percent of all admissions and higher than ever reached in the last war. In 1938, the admission rate of civilians to civilian mental hospitals was 1.1 per 1,000 population per year. This, of course, does not mean that there is forty times as much nervous and mental disease in the Army as in civilian life, since in civilian life, cases of psychoneurosis, organic neurological disease, epilepsy, and even inconspicuous insanity are not admitted to mental hospitals. The ratio merely points out that certain individuals who can get along perfectly well in civilian life, when they get in the Army, even though no more nervous than before, cannot get along, go on sick call and are admitted to the hospital.

In June 1943, the rate of medical discharges from the Army for neuropsychiatric reasons was 20 per 1,000 strength per year and 46 percent of the total medical discharges. This figure does not include the cases discharged under section VIII [AR 615–360] for mental deficiency and psychopathic personality.

This high rate of neuropsychiatric discharges also cannot be taken as a measure of the number of men who are breaking down under the strain of Army life. Many of the men were discharged not because they developed a nervous breakdown or "cracked up" but merely because it was found they could not adapt themselves to Army life. Once out of the Army, many of them will be able to go to work and function as perfectly normal human beings. Seventy percent of the medical neuropsychiatric discharges were for psychoneurosis, practically none of which will need hospital care on discharge.

VACILLATING POLICIES AND PUBLICITY BLACKOUT

Historically, one might say that through 1942 and into 1943, there was no particular planning regarding public relations in psychiatry, and, except for routine approval, there were no restrictions to the publication of psychiatric observations by medical officers except that no identifiable figures could be given. Many such publications appeared in scientific journals and consequently did not reach the public. By the end of 1943, because of concern about the loss of manpower through neuropsychiatric rejection at induction centers and subsequent discharges for neuropsychiatric reasons, the War Department inaugurated a policy [2] which placed the whole field of psychiatry under a publicity blackout. This blackout (which also applied to malaria) prohibited the release of any information on the subject and, in fact, even the mention of military psychiatry in either scientific articles or the public press. This extended over a period

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[1] It would seem, here, that Col. Roy D. Halloran, MC, is questioning the use of diagnostic neuropsychiatric terms and would have preferred some other terms, such as "combat exhaustion" or "battle fatigue."—A. J. G.

[2] Probably inaugurated by Joint Security Control, appointed in August 1942 and responsible to the Joint Chiefs of Staff.—A. J. G.

of several months. The very rigid censorship made it impossible to release, even through scientific channels, information concerning any phase of this specialty.

Action by the Chief of Staff

The concern about the loss of manpower was amplified through expressed congressional interest and reached such a degree that, on 30 December 1943, Gen. George C. Marshall, the Chief of Staff, dictated a proposed release on the subject of psychoneuroses to the Chief of Information, Maj. Gen. Alexander D. Surles. This release was eventually referred to the Surgeon General's Office where it was slightly modified and a new version written. Processing of the release required over 3 months. By that date, the total blackout had been raised, and because several general news releases had been made, the Chief of Staff's proposed release was deemed unnecessary. For its historical value, it is here reproduced:

MEMORANDUM FOR GENERAL SURLES: 30 DECEMBER 1943

We have been having increasing difficulty with members of Congress regarding physical rejections of men at induction stations. Since June 1st, about 40% of the men reporting have been rejected and during the same period more than 200,000 have been discharged from the Army for physical disabilities. The point of this particular note is that between 25 and 35 percent of both rejections and discharges were for psychological and neuropsychiatric reasons. The War Department has taken steps drastically to curtail all discharges for disability pending the promulgation of new instructions which it is believed will materially reduce the wastage of manpower.

In all of this matter, the great problem is the handling of the psychoneurotics, and I am of the opinion that we should get out one way or another some additional information on the subject. The following is a rough draft hurriedly dictated by me on which I should like your opinion and which would have to be checked by G–1 and The Surgeon General.

(Sgd) G. C. MARSHALL
G. C. M.

The following is General Marshall's rough draft:

The War Department has just completed, under the direction of the Inspector General, whose principal assistant, Maj. Gen. Howard McC. Snyder, is a medical officer, a comprehensive survey of induction and discharge processes in continental United States relating to physical rejections of inductees and discharges from the service for similar reasons. One hundred and thirty-seven stations or installations were inspected so as to assure a nationwide cross-section of the situation. As a result of this survey, new instructions have been issued which it is believed will materially reduce the number of rejections.

However, one problem remains extremely difficult of solution. It pertains to the fact that between 25 and 35 percent of all rejections and discharges for physical reasons related to psychoneurotics. While in the opinion of the several high ranking and experienced medical officers participating in this inquiry, the doctors concerned, Army, Navy, and civilian, on duty at induction stations are performing their duties in a manner which precludes any thought of predilection or partiality, this does not mean that the line officers on duty at induction stations always agree with the medical officers or that the doctors do not at times disagree among themselves. Nevertheless, it appears that all are doing their utmost to fill required quotas with the best material available.

The greatest differences of opinion relate to rejections for psychiatric reasons. Most physical defects can be seen and measured and therefore quite accurately diagnosed and appraised. Psychiatric disorders, however, are for the most part invisible, and their detection rests with professional ability and experience of neuropsychiatrists. These specialists at times have appeared either over-enthusiastic or over-cautious. In other instances, it is evident that medical personnel have been too limited in numbers or too inexperienced in training properly to diagnose the large groups of men which must pass rapidly through induction stations. As a consequence, many psychoneurotics have been inducted into the Armed Forces, with the consequent complications of a later discharge.

It is this question of psychoneurotics which is least understood and is most difficult to handle. Functional nervous diseases are recognized as entities by neuropsychiatrists but these disorders cannot as a rule be definitely measured nor confirmed by laboratory tests or objective findings. For this reason, there is a greater divergence of opinion regarding these cases than in any others. To the specialists, the psychoneurotic is a hospital patient. To the average line officer, he is a malingerer. Actually, he is a man who is either *unwilling*, unable, or slow to adjust himself to some or all phases of military life, and in consequence, he develops an imaginary ailment which in time becomes so fixed in his mind as to bring about mental pain and sickness. In a sense, this might be considered as shirking, yet among the thousands of psychiatric cases in the Army no record exists of any psychoneurotic ever having been convicted for malingering. This is because no doctor is either willing or able to state under oath that the pain complained of by the psychoneurotic is nonexistent. The doctor may believe there is no pain. He may even say so—off the record—but he cannot swear to it. For this reason, the laymen or uninitiated line officers incline to the belief that a medical officer's diagnosis of psychoneurosis is either wrong or else that the doctor is influenced by a hyperconsiderate professional attitude.

This view is emphasized in the light of certain happenings with which line officers in time become familiar. For example, at one general hospital during the course of this recent inquiry, there were approximately 85 psychoneurotic patients. Most of these were walking about, performing light duties, and appearing quite content with their lot, and with the prospect of an early discharge for physical disability. Shortly after representatives of The Inspector General arrived, rumors spread through the hospital that discharges for physical disability, insofar as psychoneurotic disorders were concerned, had been discontinued. Immediately, practically all the psychoneurotics became confined to their beds, too sick, by their own testimony, even to get up and go to meals.

A further example has been handed down from the last World War when on the publication of the Armistice some 8,000 of 10,000 shell-shocked patients were reported to have made an instantaneous recovery.[3]

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[3] This example is not supported by any known documentation. On the contrary, it is stated in "The Medical Department of the United States Army in the World War. Neuropsychiatry. Volume X," page 287, that after the armistice "the necessity for beds for neuropsychiatric patients increased for a time instead of diminished * * *" and, on page 279, "After the armistice began, new admissions [NP] to Base Hospital No. 117 declined very rapidly and a large number of men were restored to duty who otherwise would have required a considerable period of treatment. There was not, however, as has been stated, any very marked change in the character of the war neuroses or in their prognosis. It was simply possible to restore to A or B status some men who would have been classified C or D had the war continued. [A, B, C, and D represented grades of disability.] * * * The total admissions from the opening of the hospital [Base Hospital No. 117] were 3,268, 50 percent of whom were returned to combat duty and 41 percent for other military duty in the American Expeditionary Forces." Considering the 3,268 figure in the World War I history, it is difficult to understand from whence the 8,000 to 10,000 figure of General Marshall is derived. There was a recorded total of 20,309 white enlisted neuropsychiatric admissions in Europe from January 1918 through July 1919, and 7,913 white enlisted neuropsychiatric admissions from December 1918 through July 1919 (see "The Medical Department of the United States Army in the World War. Statistics. Washington: Government Printing Office, 1925, vol. XV, pt. 2").—A. J. G.

The fact remains that thousands of hospital beds are being occupied by soldiers under observation and treatment for psychoneurosis who require the services of cooks, nurses, doctors, ward attendants, and so forth, all a burden on the Army and manpower generally. Whether or not the diagnosis in their cases is correct does not appear to be half so important as does the fact that the men are occupying hospital beds and taking up valuable time of limited medical personnel. Furthermore, in most cases, the primary reason for these men being in hospitals is not because doctors made patients of them but because line officers were unable to make soldiers out of them.

The desire of commanders to be rid of below-average soldiers is understandable, particularly so when those commanders are necessarily held to rigid training schedules and the accomplishment of objectives according to a time schedule. In addition, there is no established method by which psychoneurotics can be adjusted more slowly to military service than are normal soldiers. They all must of necessity, in a huge Army, receive virtually the same treatment and undergo similar training. The standards set for all men are more or less alike, but are based on what is to be expected of the average man. However, the true psychoneurotic is not average; he cannot keep up nor assimilate military life as do the others, whereupon, as a defense measure he discovers some ailment to which he attributes the reason for his inadequacy and immediately begins to go on sick report. This latter action is quite frequently condoned, if not actually encouraged, by the officers and noncommissioned officers who have become weary of waging a losing struggle to keep the men up to the standard of other soldiers. We find in some instances that the line officers have importuned medical officers to help rid them of the burden of these particular cases, meaning of course by the method of disability discharge. As one doctor stated: "Conducting sick call is a game of wits; the man says he has it and the doctor says he hasn't." In some cases, it appears that the men are smarter than the doctors, especially the inexperienced medical officers; on the other hand, the doctors do not care to disregard the possibility that the psychoneurotic does have some organic ailment. In any event, the psychoneurotic eventually gets into the hospital. Once there, the man's potential value to the service is either destroyed or seriously impaired. There, he exchanges information regarding his ailment with other patients and from them he learns the symptoms most likely to perplex the doctors. He is recognized and treated as a sick man. He wears the clothes of an invalid. His food is brought to him. He is catered to by "gray ladies," and above all, he escapes from those duties which he seeks to evade. He cannot be punished for malingering; therefore, the worst that can happen is to be sent back to his organization where he can and will start the same process all over again. In the meantime, he enjoys a life of leisure with one great goal ahead; to wit, a discharge for physical disability, a comparatively high paid job as a civilian, a discharge bonus, and eventually a pension from the Veterans Administration Bureau.

Perhaps the most important factor contributing to the spread of psychoneurotics in our Army has been the Nation's educational program and environmental background since 1920. While our enemies were teaching their youths to endure hardships, contribute to the national welfare, and to prepare for war, our young people were led to expect luxuries, to depend upon a paternal government for assistance in making a livelihood, and to look upon soldiers and war as unnecessary and hateful. The efforts to change these teachings in a few short years have left millions of our people unconvinced. The burden of changing the minds of such people who are being inducted into the Army has fallen primarily upon the hard working young platoon leaders and company commanders of our great war Army, and the indications at present are that the problem is not yet being satisfactorily met. This is manifested by the ever-increasing number of psychoneurotic patients crowding into our hospitals. A determined effort is being made throughout the Army to better this situation. It is admittedly difficult, and also it is important that there be a general public understanding of the problem.

Reaction of Neuropsychiatry Consultants Division

The following memorandum was submitted by Col. William C. Menninger, MC, for The Surgeon General:

MEMORANDUM TO: Mr. Harvey H. Bundy 3 April 1944

With regard to the memorandum which you sent to The Surgeon General's Office, after careful re-reading, from the viewpoint of a psychiatrist, I again want to express satisfaction with the general tenor of the memorandum and with most of the comments in it.

There are certain generalities concerning the issuance of any such material to the public press which I should like to call to your attention. This memorandum was written and describes the psychiatric picture as seen in installations in this country some months ago. It deals almost entirely with Zone of Interior soldiers. There is a tendency to depreciate the type of psychoneurotic patient seen at that time in our hospitals. Since then, we have had a large number of such patients returned from the combat zone, veterans of fighting, the great majority of whom prior to their battle experience were "normally" adjusted men. There have been literally hundreds of these men awarded citations for bravery. To depreciate the whole group of such men with this diagnosis within the Army is not intended, and for this reason, I believe a closer delineation of the types of cases should be made, and probably a recognition of the combat cases as well as a host of men with psychoneurotic symptoms who carry on with their Army jobs in a highly commendable fashion.

Then I want to suggest that in a few places the reference to the physician's ability and knowledge might be worded slightly differently. Perhaps the statements made are true, but it seems to me the point can be made without possible reflection on the physicians. Thus line 5, page 132, describes some of the examiners as "over-enthusiastic or over-cautious"; page 132, line 27, intimates that the doctor might be guilty of "hyper-considerate professional attitude." On page 133, lines 25–26, it is stated that "in some cases it appears that the men are smarter than the doctors."

There are some other points which I want to suggest might be changed and a list of these is attached. If it is desired, the Division of Neuropsychiatry of the Surgeon General's Office would attempt to rewrite the memorandum, including the major portion of it as it now stands with the changes noted in the attached critique.

SUGGESTED CHANGES IN THE PROPOSED PRESS RELEASE ON THE PSYCHONEUROTIC PROBLEM IN THE ARMY

Page 131, line 7. No doubt the release from the Inspector General's Department stimulated this memorandum, but this whole problem is essentially a medical one and one which has received a great deal of attention and effort on the part of The Surgeon General and the Medical Department. So far as the public and the medical profession of the country is concerned, such information will perhaps carry a great deal more weight if such information is forthcoming from The Surgeon General.

Page 132, line 5. "These specialists at times have appeared either over-enthusiastic or over-cautious." This might be modified to indicate that initially great caution was urged and reports from oversea theaters continue to indicate a large number of men who should have been caught at the induction station examination.

Page 132, line 12. Functional nervous diseases are recognized as entities by all branches of medicine, not only psychiatrists.

Page 132, lines 15–16. "To the specialists, the psychoneurotic is a hospital patient." This is true only in the Army, and an explanation would clarify the public understanding of the reasons: An individual in civilian life, even though he may have neurotic difficulties so long as he can govern his own life and lead it as he wishes can get along, often without medical help. In the Army, this cannot happen. It is not possible to

prepare special diets in the field and soda mints cannot be included in K-rations. To have an effective army, there must be regimentation, discipline, and a strenuous existence. There is no middle ground; a man is either carrying on a job or he is a casual. Consequently, many men are sent to the hospital who in civilian life could find many other alternatives.

Page 132, line 16. "To the average line officer he is a malingerer." General Marshall certainly should know, but this seems to indicate the line officer has no discriminating judgment and no understanding of a great mass of his soldiers. Malingering, in the correct usage of the word, is regarded as rare in the Army by the great majority of our psychiatrists. On the other hand, there is a very great frequency of capitalization on complaints, no doubt exaggeration of these, a universal human trait, even in the non-neurotic but accentuated in the neurotic.

Page 132, line 18. "* * * in consequence he develops an imaginary ailment." No true psychoneurotic ailment is imaginary. This implies that the illness and/or symptoms were consciously devised in which case the man is a malingerer. In fact, the symptoms of the psychoneurotic have an unconscious origin and this is a generally established scientific fact. Suggest that "imaginary" be changed to "psychological."

Page 132, line 23. "* * * that the pain complained by the psychoneurotic is nonexistent." It is the best psychiatric judgment that, in a great many cases of certain types of psychoneurosis, the pain *is* existent. Furthermore, there are a very large number of psychoneurotic patients (conversion hysteria, anxiety hysteria, obsessional and compulsive states, acute anxiety states) who do not complain of pain.

Page 132, 3d and 4th paras. These facts are probably accurately related but should have sufficient further explanation so that it does not appear that all such individuals are fakers and all doctors in charge of them dupes. It is a universal human trait that when faced with an insoluble problem the individual reacts with his entire personality, and this may be anxiety, physical upsets, unusual behavior. When the problem is solved, these neurotic symptoms clear, but the man still has the same fundamental personality makeup as before. He is "readjusted" but not "recovered." This phenomenon is just as frequent in civilian life as in army life.

Page 133, line 1. The implication in this and the immediately following lines is to the effect that the psychoneurotic individual is not a sick man. In the Army, as stated above, there is no choice about his disposition. Were he in civilian life, he would probably not be in the hospital. If they can be rehabilitated for further service, then hospitalization is justified, and at the present time, more than 50 percent of these men are rehabilitated in the hospital. We hope shortly to have arrangements within the Medical Department to provide care for these individuals in barracks.

Page 133, lines 17–18. "* * * as a defense measure he discovers some ailment." This might infer that he consciously concocts a symptom and would be more accurate to state "he develops."

Page 133, lines 25–26. "In some cases, it appears that the men are smarter than the doctors." This is very possibly true but the point can be made that often men in this group are of superior intelligence and capable of overstatement or understatement of their illness in a convincing manner. The implication is present also that in the absence of an organic difficulty the man is not sick, which may certainly not be the case.

Page 133, line 41. In attempting to explain the contributing factors to the picture, it is urged that no reference be made to the "Nation's educational program" unless we want to offend the educational group. There are two explanations that I should like to suggest:

(a) An extremely important reason for both the high rejection rate at induction centers as well as the discharge rate within the Army is the unresolved problem of the motivation of men for war. Why should a man fight? The answer of the individual man is uncertain; it will depend on his information and his attitude and this is directly related to the attitude he has had toward the question before he comes to the

Army, formulated in civilian life. It is largely the reflection of his immediate associates—his own family, friends, and community. If he doesn't see any need to fight, and is supported in this by his civilian associates, it is an uphill job for the Army to make a soldier out of him against his own wishes.

(b) A second explanation is concerned with our culture. We are a group of rank individualists, doing what we want when we wish and the way we wish. Consideration for the group is very secondary. Even as a Nation, we were isolationists. To form an army and to fight a war, the group welfare and purpose *must* come first and the individual's wishes be secondary. There must be regimentation and discipline, two features conspicuously absent in our civilian way of life. The problem is not so much any parental coddling as it is the exaggeration of individual freedom, "doing what I want, if and when and how I please." Psychiatrically, it is a modification of the infantile, the immature stage of development, characterized by "I want what I want when I want it and to hell with the rest of the world." This great importance of the individual and his freedom is, paradoxically, the chief reason why we fight but it does not and cannot apply within the functioning army. We are rediscovering the fact that there are a large number of people whose lifelong attitudes and patterns of behavior are more important to them to maintain than are the needs and attitudes of the group.

Leaks to the Public Press

The blackout had other interesting results. Later in 1943, soon after it was enforced, there was sufficient leakage of information that the lay press became interested and curious about neuropsychiatric problems. There were many evidences of such leakage. A proposed release submitted by Colonel Halloran to the Director, Office of Technical Information, SGO, on 25 September 1943, was disapproved by the War Department Bureau of Public Relations. Yet, a few days later, an article appeared in the *Washington Post* which said: "Mental cases trebled over World War I. O.W.I. [Office of War Information] reports heavy draft rejection, more crackups. Rejections 3 percent last war, 8–10 percent this." The latter figure appeared prominently in the proposed but disapproved release. In general, some of the figures which were periodically quoted at times were nearly correct and at other times exaggerated.

One particular figure that 30,000 neuropsychiatric cases were being discharged per month was widely circulated. Actually, the highest number discharged in any one month was 26,000, and the average range was between 10,000 and 20,000. Thus, information reached the public, sometimes fairly accurate, sometimes distorted, and frequently misunderstood by both those who wrote it and those who read it.

Policy of the Surgeon General's Office

Reporters did come to the Office of Technical Information and, in turn, were referred to the Neuropsychiatry Consultants Division. One such energetic reporter who had gleaned information from many sources brought the following prepared outline:

1. We have read in various publications contradictory statements about the inci-

dence of psychiatric cases in the Army. We understand that although you have screened out five times as many men at induction as you did in the last war, nevertheless you apparently are having twice to three times as many cases in this war as you did in the last. Is this true? We read that almost 50 percent of the medical discharges from the Army are for psychiatric reasons, and that this runs as high as 10,000 per month; in other words, that you are losing the equivalent of almost a division per month for psychiatric reasons. Is this true? We read that in continental United States the psychiatric admission rate is 50 per 1,000 strength per year. Assuming a strength of 5,500,000 men in the Army in this country this would indicate that the equivalent of 18 divisions per year are breaking down during training. Is this true?

This looks like a very serious situation. Could we have a comprehensive picture of the true situation?

2. What are the reasons why these rates are so high?
3. What is the Army doing to meet this problem?

In this case and in every other case, the Surgeon General's Office had to meet the questions with the refusal to give information. Such reporters or feature writers would leave frustrated and annoyed, questioning why the Army was trying to hide certain facts. Explanation that it was withheld because of security reasons did not satisfy the press. The reason the Joint Security Control always gave was that knowledge of the number of neuropsychiatric casualties would give aid and comfort to the enemy as well as serving propaganda material. It was never learned whether the danger in this direction was ever weighed against the great handicap and harm that it was causing on the homefront.

Leak of General Marshall's Memorandum

Another incident of special significance occurred in January 1944. An article, distributed by the North American Newspaper Alliance, appeared in the 9 January issue of the Washington, D.C. *Sunday Star,* which could properly be designated as chiefly based on a presumed "leak" of General Marshall's memorandum to General Surles on 30 December 1943.[4] The language in the syndicated newspaper article closely resembled that in the memorandum. The terminal statement in this article about there being "probably four malingerers to one true neuropsychiatric patient" was probably obtained from another source. This article was grossly untrue and presumed to have been released by the Army.

The Surgeon General's Office had not been consulted despite the obvious neuropsychiatric subject matter. Because such an important principle of clearance with proper authorities was at stake and because the statement was so grossly wrong, a protest and recommendation was lodged by the Neuropsychiatry Consultants Division through The Surgeon General to the Office of Technical Information. The blackout was in force and nothing was done about it. The article and The Surgeon General's critical memorandum follow.

[4] It took 3 months for General Marshall's proposed release to reach and be answered by The Surgeon General's staff, but during the interim, obvious leaks to the press had been made.—A. J. G.

"MALINGERING" IN ARMY BLAMED BY OFFICERS ON FALSE EDUCATION

In an unpublished report surveying recent medical discharges, Army officials have blamed the youth programs and policies of the last quarter century for the high degree of malingering noted among inductees in American Army training centers, it was learned here yesterday.

While youths of the Axis nations have been subjected to training designed to toughen them against the rigors of war, members of the rising generation in the United States have been taught to believe that the world owes them a living, and that they have a right to expect their Government to support them in luxury, Army officials complained.

The report, it was learned, was undertaken by the Army medical officials when Congress began to show an interest in the fact that about 40 percent of the draftees in recent months have been rejected on medical grounds, while large numbers have been given medical discharges after induction and during their combat training.

Steps have been taken, it was reported, to diminish sharply the number of rejections and discharges based directly on physical grounds, but no way has been found to correct the difficulty encountered in the neuropsychiatric cases which constitute, it was estimated, from 25 to 35 percent of all rejections and discharges.

Many Report to Hospital

In this connection, the report of the Army investigators pointed out that doctors could readily measure and appraise the seriousness of physical disorders, ailments and shortcomings, but were helpless to measure with any degree of accuracy or certainty the seriousness of the neuropsychiatric disorders which they encounter so frequently.

Men who are unable, unwilling, or slow to adjust themselves to Army life, they explained, consciously or unconsciously develop symptoms of illness and report for sick call. They go to a hospital where they have their meals brought to them and receive all kinds of care and attention, not only from the medical staff but from the "gray ladies."

In the hospital they also have an opportunity to talk with other patients, comparing symptoms and getting ideas as to other complaints they can discover at opportune moments if it appears they are about to be sent back to the stern and arduous routine of Army camp life.

Symptoms Develop Anew

None of these men is ever convicted of malingering, because no doctor is prepared to state under oath that the patient really does not experience the pain or disability of which he complains. If returned to camp routine, the patient simply develops his symptoms all over again and goes through the same process of hospitalization where he takes up space that may be needed for other sicker patients, and where he takes up the time and attention of an already overworked staff of doctors and nurses.

The line officers, unable to make a soldier of him, are glad to get rid of him, and the overworked hospital staff is likewise glad to see him get a discharge.

So out he goes, into civilian life again, with a bonus, perhaps, and a disability pension for the rest of his life.

In some cases, the report declares, his ailment is undoubtedly real, and as there is no way to distinguish with certainty between the true neuropsychiatric and the malingerer, this works a grave injustice on the truly sick man. The report estimated, however, that there were probably four malingerers to one true neuropsychiatric patient.

11 JANUARY 1944

MEMORANDUM FOR: The Commanding General, Army Service Forces:
(Attention: Lt. Col. John D. Witten, Room 3E 634 Pentagon Building, Washington 25, D.C.

Subject: Incidence of Malingering in Military Personnel.

1. In the 9 January 1944 issue of THE SUNDAY STAR (Washington, D.C.), page A–19, appears an article under the headline "Malingering in Army Blamed by Officers on False Education." In the article, Army officials are claimed to have stated that there is a high degree of malingering among inductees and trainees in the American Army; that there are four malingerers to one neuropsychiatric patient; that none of these malingerers is ever convicted because doctors are unable to distinguish between malingering and psychoneurosis.

2. The above statements appearing in this newspaper article are grossly untrue. If these statements actually arose from an official source, this source obviously was not cognizant of all the facts. The incidence of malingering in the Army or at induction centers has been extremely low in this war. Repeated and extensive investigations of this matter have been made by the Surgeon General's Office both in induction centers and in the field. There is conclusive evidence that malingering, in any form, is less than 1 percent of all patients. Furthermore, in contrast to the statement made in the newspaper article, malingering is not difficult to detect but very easily recognized by any trained medical officer.

3. It is believed that the appearance of these erroneous statements attributed to an official Army source is misleading to the public, harmful to psychiatric patients among military personnel, and casts unjustified implications of incompetence on the Medical Department.

4. It is recommended that (a) an official refutation of the statements be issued by the War Department; and (b) official statements pertaining to neuropsychiatric conditions not be released to the public unless they have been approved by The Surgeon General.

NORMAN T. KIRK,
Major General, U. S. Army,
The Surgeon General.
(Capt. John W. Appel, MC) [5]

PUBLICITY BLACKOUT CONTINUES

The Office of Technical Information, SGO, with the assistance of personnel in the Neuropsychiatry Consultants Division, formulated a number of press releases dealing with the neuropsychiatric problem. In February 1944, for instance, an informative fact sheet was prepared entitled "The Mental Health of the U.S. Soldier" which was especially directed to the woman in the home. Like all other efforts, the total publicity blackout prevented its release and thus negated another effort to bring important information into the American home.

Further Efforts

In contrast to the policy as represented by the blackout, it was the opinion of the Neuropsychiatry Consultants Division, strongly supported by The Surgeon General, that there should be a frank, open presentation of this subject. Far too many individuals were involved to cloak it in secrecy when information could be given that would in no way reveal the detailed statistics of the problem. Because the situation had become so acute, in

[5] It would appear from this letter that Captain Appel was unaware of General Marshall's memorandum at this time.—A. J. G.

February 1944, the Neuropsychiatry Consultants Division drew up a policy recommending that releases should be given, characterized by absolute frankness and honesty about the total situation. This policy was strongly approved by Maj. Gen. Norman T. Kirk, The Surgeon General, and the recommendation was sent to the Joint Security Control who had imposed the blackout. They submitted it to the Navy who concurred with this recommendation, but on 18 March, the memorandum was returned with very limited permission to give any facts and no figures. This resulted in essentially the continuation of the blackout.

During the next 2 months, repeated efforts through personal calls on higher echelon were made by the members of the Neuropsychiatry Consultants Division and the Office of Technical Information. It was hoped that the censoring powers would understand the necessity for and desirability of releasing such information. The basis for the recommendation was essentially that many psychiatric casualties from basic training camps were being released from the Army and returning to their homes; there, being misunderstood, mistreated, and looked upon with suspicion. Communities were rapidly becoming aware of their presence but, without any guidance for their management, were unable to make plans for such guidance. War Department Circular No. 111, which was issued on 18 March 1944, set forth the policies governing the release of military information, but this in no way referred to the psychiatric problem. The Office of War Information was keenly aware of the problem and in March prepared an article on "Morale in the Armed Forces of the United States" without advice from the Surgeon General's Office. Unfortunately, it contained many erroneous facts and was not concurred in by the Neuropsychiatry Consultants Division.

Crises Develop

The blackout continued into April. The situation became more and more acute because of pressure from communities who were asking guidance from The Surgeon General on the subject of neuropsychiatric casualties; because of pressure from news and magazine writers who were becoming more and more suspicious that the War Department was hiding some kind of dirty linen; and, further, because of pressure from the American Psychiatric Association, the national organization of psychiatrists of some 3,500 strong, which was planning a meeting in May in Philadelphia. A considerable portion of that meeting was to be devoted to the presentation of scientific papers from psychiatrists in the Armed Forces. Since their scientific papers could not be released, the meeting would, of necessity, have to be called off. The meeting was to be essentially a "war" meeting with many important advantages to the military in evaluating the psychiatric problem, concerned with the Army and the war, exchanging ideas as to methods and management, diagnosis, and treatment.

PUBLICITY BLACKOUT SLACKENED UNDER PRESSURE

In addition to considerable civilian pressure on War and Navy Department authorities, two special test cases were made. One of these was a paper prepared by Lt. Col. Malcolm J. Farrell, MC, and Maj. John W. Appel, MC, both of the Neuropsychiatry Consultants Division, summarizing the Army experience and the situation as to that date. It was with great effort that this was hand-carried through various echelons to obtain approval, which was finally approved with all figures deleted. The director of the division had also prepared a paper for the annual banquet of the American Psychoanalytic Association meeting, to be held at the same time. This paper was finally sent to one of the assistants to the Secretary of War, who in turn called it to the personal attention of the Chief of the Bureau of Information. When initially submitted, it had been radically censored. When returned from the Director of the Bureau of Information, it was essentially restored to its original form and approved.

Because of the pressure from these many sources, the Joint Security Control, in a memorandum of 28 April 1944, revised the policy on publicity regarding neuropsychiatry, as follows:

MEMORANDUM FOR: Director, Bureau of Public Relations, War Department.
Director, Office of Public Relations, Navy Department.
Subject: Policy on Publicity Regarding Neuropsychiatry.

1. Statistical information by percentages, rates or numbers of neuropsychiatric casualties in the armed service, either by units, theaters of operations, combat troops, service troops, or arms of services is classified. The release of statistical information as indicated above constitutes a violation of AR 380–5 and Article 76, Navy Regulations.

2. The following policy will govern all Army and Navy releases for publication of information concerning neuropsychiatric casualties of the Armed Forces.

a. No statistics (percentages, rates or numbers) of neuropsychiatric casualties in the Armed Forces will be released at this time. NOTE: No objection will be interposed to publication of percentages *only* of recoveries of neuropsychiatric casualties.

b. No names or identifiable photographs of neuropsychiatric cases will be released nor will there be any mention or description of neuropsychiatric casualties in any specific unit which might identify the unit or the individual.

c. All material on this subject cleared in oversea theaters will conform to paragraphs a and b.

d. All material on this subject originating within the continental limits of the United States will be checked for accuracy by the Surgeon General's Office, U.S. Army, before final clearance by the Review Branch, War Department Bureau of Public Relations. In the case of the Navy, all such material will be checked for accuracy by the Bureau of Medicine and Surgery, U.S. Navy, before final clearance by the Review Section, Navy Department Office of Public Relations.

For Joint Security Control:

J. M. CREIGHTON, *Captain, U. S. N., Navy Executive.*
J. K. COCKRELL, *Colonel, Cav., Army Executive.*

While this policy placed sharp restrictions on all figures, by inference, it did at least permit the discussion of the problem and of the methods in

dealing with it and also permitted those in the field of psychiatry to discuss the subject publicly in the press and in popular and scientific magazine presentations. It also permitted the American Psychiatric Association to hold its meeting in May. It precipitated a press conference on 9 May by Maj. Gen. Norman T. Kirk, The Surgeon General, and the director of the Neuropsychiatry Consultants Division. This press conference was attended by an unusually large number of reporters and continued for more than twice the length of time usually allotted to such conferences. General Kirk issued a statement which was then distributed by the Office of Technical Information.

The statement and prepared copy for distribution briefly and generally explained the psychiatric situation. The press was called upon to exert their influence and to explain to the American people the misconceptions regarding psychoneuroses and psychoses. The fallacy of attempting to categorize in advance, by screening, the potential response of all inductees to stress and combat was mentioned. General Kirk praised the American soldier as a fighter and commented on those exhausted by the strain of battle who responded to treatment and returned to their combat units. Still, no figures, statistics, or even percentages were given.

The press conference was followed by a radio report by The Surgeon General and by the director of the Neuropsychiatry Consultants Division, on the March of Time Program, 11 May 1944, followed by a joint radio presentation by the Surgeon General of the Navy and the director of the Neuropsychiatry Consultants Division on 18 May 1944. Numerous popular articles began to appear in current magazines.

EFFORT TOWARD FURTHER LIBERALIZATION OF PUBLICITY RELEASES

Despite the liberalization of the policy as set forth on 28 April 1944, it was still not possible to give any figures—percentages regarding incidence, casualties, and discharges—of neuropsychiatric cases, even though these figures would not have identified any group or theater. It was only possible to give vague generalizations. It was never possible to give the proper perspective to the magnitude of the problem nor any guidance to a specific community as to how big their individual problem might be. The constant barrage and number of inquiries was reported by the director of the Office of Technical Information as being greater in the field of psychiatry than in any other subject concerning the Medical Department. It was felt extremely important that some planned program should be outlined and carried forward, taking the aggressive leadership in the situation rather than waiting for the necessity to defend or explain some particular incident or finding that came to some critic's attention. The division, therefore, drew up such a policy and submitted it to the Office of Technical Information but no action was ever taken on these suggestions.

Inspector General Criticizes Blackout

An event transpired in September 1944 of major significance in the development of the neuropsychiatric problem in the Army. Apparently, one of the articles in a popular current lay magazine on the subject of psychoneurosis disturbed some officer high in the War Department. He presumably took the initiative to suggest to the Deputy Chief of Staff that the subject might very profitably be investigated. Directions from the Deputy Chief of Staff to G–1 (personnel) asked G–1 to plan and carry on an investigation and to submit recommendations concerning the subject of psychoneurosis within the Army. This led to an extensive investigation on the part of the Inspector General lasting over a period of several months. One of the pertinent facts in the final report from G–1 to the Deputy Chief of Staff from G–1, on 16 February 1945, was indicated in the succinct paragraph, "* * * part of the confusion on the part of the public about the subject of psychoneurosis has been due to the complete blackout of publicity by the Joint Security Control of the Army and Navy until May 1944. Since then, only fragmentary information has been released. It was agreed that publicity insofar as possible should be given in a factual and nontechnical manner." In the same report under the recommendations was the following: "* * * that full publicity of the psychiatric problem should be given in a factual manner." This entire report along with the recommendations was approved and returned in March 1945 to G–1 to implement. One of the recommendations was that the Bureau of Public Relations be requested to assign a full-time public relations officer to handle the planning and execution of a program relative to publicity and public education of psychiatry in the Army. This recommendation, unfortunately, was never implemented.

On 21 February 1945, the Joint Security Control did ask the opinion of the Bureau of Medicine and Surgery of the Navy Department, and the Office of The Surgeon General of the War Department, as to the advisability in view of the overworked staff in Washington, whether it was necessary to submit all material on the subject of neuropsychiatry originating within the continental limits of the United States to the Surgeon General's Office to be checked for accuracy before being released for publication.[6] The Surgeon General's reply to this was to the effect that stories for local publication should be cleared by a local public relations officer after a review by a member of the medical staff familiar with the subject and that material for national publication should be cleared by the War Department Bureau of Public Relations and the Surgeon General's Office.

In an effort to implement the recommendation of G–1 that there should be a full-time man devoting his energies to the public relations aspect of neuropsychiatry in the Army, a conference was held on 21 March

[6] This reaction of the Joint Security Control was probably generated by criticism of the Inspector General in his 16 February 1945 report.—A. J. G.

1945, with representatives of the War Department Bureau of Public Relations, The Surgeon General, and the Air Surgeon. One of the conclusions of this conference was the request that Capt. Steve McDonough, of the Office of Technical Information, SGO, prepare a document on the popular aspects of neuropsychiatry which, apparently, was to be considered as a "bible" and was to be used as a guide to the policy of releases of information on this subject. This assignment, probably with good intention, was a totally impossible task since it would have taken nothing short of a manual of hundreds of pages to cover the total picture of neuropsychiatry and its ramifications in the Army. So far as is known, there was an abortive attempt to prepare such a document, but it is not known whether it was ever completed or returned to the War Department Bureau of Public Relations. On the other hand, on 30 March, the Headquarters of the Army Air Forces did issue an instructional letter to the Chief of the Office of Information Services on "Publicity on Psychiatric Approach to Rehabilitation of Returnees." Its purpose was to serve as a publicity guide for this very limited field.

Public Education Needed

Through the months of April and May 1945, the Neuropsychiatry Consultants Division continued its efforts to bring to the attention of the proper authorities the importance of and the need for a planned program of public education. This was more and more obvious in its necessity because of the increasing misinformation that was appearing in current magazines and over the radio. Many veterans were returning home. In addition to the problems inherent in handling information relative to the psychiatric casualties, a special problem arose through the release of well-intentioned but misguided information relative to the ordinary soldier who was being discharged. Many articles were appearing on how he should be "handled." So many articles appeared that counterpropaganda began to appear written by the veterans themselves or by energetic news reporters trying to indicate the veteran's resentment against being regarded as a problem child. This aspect, coupled with the many continued requests, led the Neuropsychiatry Consultants Division to prepare a further brief on the situation, as follows:

DRAFT 29 MAY 1945

1. Attention is again called to the urgent and immediate need for a planned program of public education on the neuropsychiatric problem, precipitated by the war. In spite of requests from G–1 to the Bureau of Public Relations in March, no plan has been developed. This urgent need is indicated because of:

a. The magnitude of the problem as it has occurred in the Army which with its present and future civilian implications should be known in order to intelligently plan the civilian program:

(1) 1,825,000 men have been rejected for military service because of psychiatric disorders—39 percent of men rejected for all causes.

(2) More than 287,000 men have been discharged from the Army with certificate of disability up to 1 April 1945 for neuropsychiatric reasons, or 43 percent of all CDD's.

(3) 127,000 men with neuropsychiatric difficulties have been discharged on an administrative basis.

(4) There have been 740,000 admissions to Army hospitals because of neuropsychiatric disorders.

(5) There were 34,333 men and women under neuropsychiatric treatment in Army hospitals as of 30 March 1945, or 13.9 percent of all hospital patients.

b. Much confusion still prevails as to the types of neuropsychiatric disorders, and proper emphasis must be brought to bear to educate the public regarding these types.

(1) The great majority are relatively mild disorders known as psychoneuroses, men for the most part compatible to civilian existence.

(2) The man seriously ill, known as psychoses, who requires hospitalization. Eighty percent of these will recover.[7]

(3) A large group of chronically maladjusted individuals recognized as misfits because of emotional immaturity or mental defectiveness.

c. The public should know the effective treatment program being carried out in the Army for the handling of this problem, specifically:

(1) At the present time, twenty-two general hospitals have specialized services for the treatment of the psychotic group and are returning five out of six of these men recovered, to their civilian community.[8]

(2) At fourteen convalescent hospitals, effective treatment returns from 20 to 50 percent of the psychoneurotic patients to further duty in the Army and a high percentage of the remaining are sufficiently recovered to return to normal living.

(3) The method of frontline treatment for combat neuropsychiatric casualties is returning 60 percent of this group to further combat duty and 30 percent to further duty in the noncombat zone.

(4) Effective preventive treatment is being carried out by division psychiatrists in divisional combat units and by psychiatrists in Mental Hygiene Consultation Units in every basic training camp.

(5) Psychiatrists are effectively working in each correctional installation in the Army, aiding in the evaluation and rehabilitation of military offenders.

d. Our soldiers returning to civilian life who have psychiatric difficulties are confronted with these major problems:

(1) The misunderstanding of families and communities as to the nature of psychoneuroses.

(2) Difficulties in obtaining jobs because of misconceptions on the part of employers of this problem.

(3) The lack of available facilities in communities for the guidance and utilization of this group, including educational, vocational, recreational, and medical.

e. These difficulties of readjustment could be alleviated and the transition of

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[7] This optimistic prediction of "recovery" rate might be more correct if considered as "remission" rate. Eli Ginzberg and associates (The Ineffective Soldier: Patterns of Performance. New York: Columbia University Press, 1959) state that 55,000 were discharged from the Army in World War II for psychosis (p. 20); that 1 out of 4 separated with a diagnosis of psychosis made an early adjustment (p. 199); and that, in 1953, 11,700 World War II veterans were admitted to Veterans' Administration hospitals with psychosis (p. 172). This latter figure was certainly not all new cases but must include a good percentage of relapses. See also Ripley, H. S., and Wolf, S.: Course of Wartime Schizophrenia Compared With Control Group. J. Nerv. & Ment. Dis. 120: 184–195, September–October 1954.—A. J. G.

[8] This statement cannot be supported. Menninger in "Psychiatry in a Troubled World" (p. 346) states: "After intensive effort (treatment) was instituted, 7 of 10 psychotic patients were well enough to send to their homes." These included acute temporary psychotic episodes and alcoholic psychoses. In this same volume (p. 598), the percentage of patients returned home alone or to the custody of relatives from 8 general hospitals that had the majority of psychotic patients was 59.1 percent.—A. J. G.

a man from Army to civilian life made easier and smoother by a planned program of public education. It would seem imperative that the influence and example of the War Department be utilized in the development of such a program.

2. The security problem since V–E Day should materially be relaxed in this field in view of the increasing magnitude of the problem. The present policy on publicity regarding the neuropsychiatric problem, which permits the use of figures only on the percentage of men recovered, is not conductive to an enlightened public attitude on one of the largest and most acute social problems of today.

It is strongly recommended that a general education program be initiated in an attempt to counteract the many present misconceptions in this field, the injustices now being perpetrated on the veteran so afflicted and the floundering state of affairs in communities in their attempts to be of help to him.

Unfortunately, it is believed that this appeal never went further than an intraoffice memorandum. The director of the division, who had composed this draft, left for a period of temporary foreign service, and it is believed that it was never followed through. The policy enunciated in April 1944 continued to be the guide, prohibiting the release of any factual information except a general verbal description of the problem.

On 29 June 1945, Joint Security Control issued a memorandum, again listing "Topics To Be Withheld From Publication." In this memorandum, there was the specific note under miscellaneous subjects which read as follows: "Statistics (percentages, rates, numbers, names or identifiable photographs) of Neuropsychiatric Casualties." Again, it was believed that the public demand was being ignored, the need of the community being overlooked, and the national health being jeopardized by this limitation in the publication of information regarding psychiatry in the Army. As a result, the Neuropsychiatry Consultants Division again prepared a comment on this restriction as follows:

Ref. to JSC/B25, Serial 6116 from The Joint Chiefs of Staff, dated 29 June 1945, SUBJECT: List of Topics to be Withheld from Publication.

1. The above mentioned memorandum includes under P. VI, B, 2. "Statistics (percentages, rates, numbers, names or identifiable photographs) of neuropsychiatric casualties."

2. Attention is called to a memorandum from G–1 to the Deputy Chief of Staff (WD GAP 710 Mar 1945) in which it was stated that "part of the confusion on the part of the public about the subject of psychoneurosis has been due to the complete blackout of publicity by Joint Security Board of the Army and Navy until May, 1944. Since then only fragmentary information has been released." In the recommendations, subsequently approved by the Chief of Staff, was included "that full publicity of the psychiatric problem should be given in a factual manner."

3. In view of (a) the magnitude of this problem as it affects national life and the urgent need for frank and extended public education in this field, and

(b) the support and aid which the War Department can give to those veterans discharged for neuropsychiatric causes, and

(c) because of the great need to educate military officers as to the extent of the problem, and therefore their responsibility for preventive efforts,

it is strongly recommended that reconsideration be given to the above stated limitation.

4. It is believed that since the combat period in Europe is completed, that security reasons for suppression of such information gained in those theaters have diminished.

5. The NP Consultants Division, SGO, strongly recommends that the limitations be revised so that

a. Statistics on incidence (percentages and rates) of neuropsychiatric casualties in the Pacific Theaters be withheld, but not those from other (inactive) theaters; providing strength and location of organizations are not revealed by the statistics.

b. Statistics on incidence and discharge of neuropsychiatric cases in ZI be made available.

c. The previous policy of giving percentages of men salvaged or returned to duty in all theaters and in the ZI be continued.

6. Consideration be given to the fact that tremendous educational value may accrue to the benefit of the Army, the public, and ultimately the individual psychiatric patient, through the utilization of carefully developed motion pictures and photographs of neuropsychiatric activities. These would in some instances, of necessity, include "identifiable" patients. Therefore, it is recommended that the restriction given above be modified to permit such photos, taken under Army supervision.

This protest was included in a memorandum from Brig. Gen. Stanhope Bayne-Jones, Chairman of the Board of Declassification of Medical and Scientific Reports of the Surgeon General's Office. His memorandum of 3 August 1945, addressed to the Joint Security Control, was as follows:

Subject: Neuropsychiatry Publicity Policy
TO: Joint Security Control
Attention: Colonel J. K. Cockrell, Army Executive
Room 2B656, Pentagon Building

1. The Joint Security Control document, subject: "List of Topics to be Withheld from Publication in Unclassified Documents," dated 29 June 1945, Paragraph VI, B, 2, states that among the subjects to be withheld from publication are "Statistics (percentages, rates, numbers, names or identifiable photographs) of neuropsychiatric casualties." Although the representative of the Office of The Surgeon General concurred in this statement at the meeting with the Subcommittee on Publication Policy, OSRD, when this was recommended, he was not aware at that time of consideration which was being given to this subject by G–1 and of certain new developments in the field of public relations with regard to neuropsychiatry. Request is now made, therefore, for review of the above quoted statement and recommendation is made for the adoption of the following policy.

a. Information regarding neuropsychiatry will be divided into the following classes:

(1) *Classified*

(a) Statistics on incidence (percentages and rates) of neuropsychiatric casualties in the Pacific Theater.

(b) Strength and location of military organizations in active theaters.

(2) *Unclassified*

(a) Statistics on incidence (percentages and rates) of neuropsychiatric casualties in all inactive theaters.

(b) Statistics on incidence and discharge of neuropsychiatric cases in the Zone of Interior.

(c) Statements of percentages of men salvaged or returned to duty in the Zone of Interior. (This would be a continuation of a previous policy.)

(d) Carefully prepared motion pictures and photographs of neuropsychiatric activities, including in some instances "identifiable patients," such films and photographs to be prepared under Army supervision.

2. The bases for the above recommendations are as follows: The public relations and publicity policy with regard to neuropsychiatry involve a problem of great magni-

tude. It affects the national life. There is an urgent need for frank and extended publication in this field. By a liberal policy of public education, the War Department can give its support and aid to those veterans discharged for neuropsychiatric causes. Furthermore, there is a need to educate military officers as to the extent of the problem and their responsibility for preventive efforts. With regard to the release of figures from inactive theaters, it is believed that since the combat period in Europe is completed, security reasons for supervision of information gained in European and Mediterranean theaters have diminished. With regard to the recommendation about photographs and motion pictures, it is strongly believed that great educational value may accrue to the Army, the public, and ultimately the individual psychiatric patient through development of motion pictures, photographs of neuropsychiatric activities.

3. With regard to certain previous considerations of the question, the following information is supplied: In October 1944, the Assistant Chief of Staff, G–1, began extended consideration of this subject. The Inspector General made an investigation and reported on 18 December 1944. A memorandum for the Deputy Chief of Staff from G–1, dated 16 February 1945, reviews the situation and points out that part of the confusion on the part of the public about psychoneurosis had been due to the complete blackout of publicity which existed until May 1945. The memorandum continues with the statement, "Since then only fragmentary information has been released." It is agreed that publicity insofar as possible should be given in a factual and nontechnical manner. This memorandum concluded with several recommendations, one of which was as follows:

"*f.* That full publicity of the psychiatric problem should be given in a factual manner."

A number of the recommendations advanced in this memorandum of 16 February 1945 for the Deputy Chief of Staff have been put into effect. However, information indicates that the recommendation cited above with regard to full publicity given in a factual manner has not been put into effect. The representative of The Surgeon General is informed by G–1 that this memorandum received the approval of the Chief of Staff on 27 February 1945.

FOR THE SURGEON GENERAL:

ROBERT J. CARPENTER,
Colonel, Medical Corps,
Executive Officer.
S. BAYNE-JONES,
Brig. Gen., USA, Chairman,
Board of Declassification of
Medical and Scientific Reports.

RESTRICTIONS LIFTED AS WAR ENDS

The director of the Neuropsychiatry Consultants Division appeared personally with General Bayne-Jones before the Advisory Committee of the National Research Council on the subject of public information. This committee approved their recommendation to the Joint Security Control after the end of the war. On 23 August 1945, the Joint Security Control published a new memorandum on the publicity policy regarding neuropsychiatry. Essentially, this memorandum was the culmination of the efforts of 2 years, permitting the release as unclassified of all material, statistics, and figures about neuropsychiatry with the exception of statistics on incidence (percentage and rates) of neuropsychiatric casualties in an

"active theater and the strength and location of military organizations in an active theater." At the time of its release, the European theater had become inactive and there were signs that the Pacific theater would shortly be closing. This did occur on 2 September 1945, thus making all information regarding neuropsychiatry as unclassified and therefore unrestricted in its presentation to the press or other agencies.

This long battle to permit The Surgeon General to function effectively in this field was of special interest in many ways. While the battle was eventually successful, it was too late to have accomplished much of the good that could have been accomplished had a planned program been undertaken 18 months previously. Attempts to obtain aggressive action in public education were not limited to the War Department. Contacts were established with the Office of War Information which did do some effective work. Contact was made with the War Advertising Council who, in preparing their various campaigns on veterans' readjustment, very carefully avoided the psychiatric problem. The Committee on Neuropsychiatry of the National Research Council was informed on the problem. The director of the Neuropsychiatry Consultants Division appeared before the Council of the American Psychiatric Association on 18 December 1944 with the following statement of the problem:

Public education relative to psychiatry. The veteran discharged for neuropsychiatric reasons (and there have been a considerable number) returns to civilian life amidst a welter of misunderstanding. He has an unclear understanding of himself. His family misunderstands him. His friends misunderstand him. Perhaps most important, his employer may misunderstand him. At least an effort to correct this situation would be the development of a long-range program of public education using every available medium, the screen, radio, magazines, and newspapers. In addition, there could very well be organized programs outlined for State and County Medical Societies, special programs outlined for women's clubs, for service clubs such as Rotary and Kiwanis, for industrial groups, for labor organizations. The organization of a speaking bureau seems very much in order.

Not only would such a plan help the returning veteran, but is one of the opportunities referred to above in our present situation created by the war, a golden opportunity to straighten out some of the misconceptions relative to psychiatry.

I am not unaware of the fact that there has been considerable argument as to whether the American Psychiatric Association should attempt to organize this program. It has been suggested that it is not the organization that should carry out such a campaign, with which I must bluntly disagree. It seems to me that it is the responsibility and the fundamental responsibility of organized psychiatry to assume the leadership for this job, whether they themselves do it or whether arrangements are made with the National Committee on Mental Hygiene or some other organization. To me it seems to be quibbling because if the leadership isn't supplied by organized psychiatry, to whom could one turn for leadership in such a program? As I have indicated, this is a very rare opportunity and challenge for the profession of psychiatry, and that's my business. Not only my livelihood but my main interest in life is in this field, and consequently when there are misconceptions that reflect on my patients, that concern their welfare, that concern my methods, that are inseparably bound up with my whole life interest, it doesn't make sense to me to say that I have no responsibility for it or that my professional standards prevent me from giving leadership or participating in such

a program. I feel that the responsibility is in our laps and it is our choice as to whether we miss the boat or whether we are able to capitalize on it and meet the need. From my vantage point, it is number one problem and number one need.

CONCLUSION

It would be impossible to estimate the time invested by the Neuropsychiatry Consultants Division in the field of public relations. Again and again, reporters would appear, usually unannounced, and, regardless of the pressure of other acute demands, would require literally hours to interview. The subject was delicate; the relations with the press had previously been strained; there was no one informed in or provided by the Bureau of Public Relations to do the job. Despite major efforts, the success achieved in this field can be considered only in the dimmest light. No planned program was ever successfully sold to those higher in authority nor any implementation to bring such about. The inevitable conclusion from this experience indicates the strong desirability of having someone on the Bureau of Public Relations of the War Department whose chief function is to plan and guide a public education program, covering the ramifications of psychiatry as it is applied in the Army—selection, classification and assignment, adjustment problems, hospitalization, treatment methods, mental hygiene clinics, correctional institution psychiatry, disposition methods of war casualties, and veterans' problems in this field. If we are to learn any lesson, it would certainly be the importance of establishing a full-time public relations officer in this field in the case of any emergency. Such an individual should be appointed early, working in close liaison with the Surgeon General's Office but with the authority of the War Department to release such information as seemed indicated from the social and medical point of view. Only by such a method can impending problems be attacked aggressively and the public educated, thereby avoiding the experience of this war when the War Department and the Surgeon General's Office were so often placed in a defensive role, and the common welfare of communities ignored.

Credit should be given to the many general hospitals and special hospitals which through their own public relations officers did produce some extremely helpful and informative psychiatric information. Particularly commendable were the efforts at Mason General Hospital, N. Y., Darnall General Hospital, Ky., Kennedy General Hospital, Tenn., and Northington General Hospital, Ala. Particular individuals in the War Department Bureau of Public Relations and various echelons were extremely helpful, notably Lt. Col. Robert Brown, Lt. Col. Harry Lutgens, Maj. Munro Leaf, and Capt. Steve McDonough. There were a few outstanding civilian newswriters who took a special interest in the field of neuropsychiatry, notably Will O'Neil of the *Chicago Sun,* Marjorie Vandewater of *Science Service,* Albert Deutsch of the newspaper *PM,* Mr. David

Dietz of Scripps-Howard syndicate from Cleveland, and Col. Joseph Green of the *Infantry Journal.*

Nearly every psychiatrist in the Army experienced, to some degree, the necessity for selling himself and his wares. This was true especially in his dealings with Medical Department officers—above all, with those in command positions. The situation was, in part, a carryover from civilian life, where the layman is occasionally better informed psychiatrically than the medical person and is more willing to consider psychiatric advice. That such a problem existed, however, was due largely to the glaring deficiencies in the psychiatric education of doctors, especially in medical schools, which came to light in bold relief during the war. Of course, some of the difficulties resulted from the actions of some poorly informed and injudicious members of the psychiatric specialty. Often one heard the expression, particularly from medical officers: "You don't look or act like a psychiatrist. You look normal." Early in the war, these same difficulties were experienced from the lowest echelon up to the Washington level.

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CHAPTER VIII

Selection and Induction

Ivan C. Berlien, M.D., and *Raymond W. Waggoner, M.D.*

HISTORICAL NOTE

One of the most important lessons learned from World War I was the high cost of medical care for veterans suffering from nervous and mental disorders which, by the time of World War II mobilization, had reached approximately $1 billion. Psychiatrists, in general, as well as others in responsible positions in Government, believed that this staggering expenditure emphasized or highlighted an urgent need for preventing the induction of mentally unfit registrants. Further, World War I experience had demonstrated that it was also uneconomical, both from the standpoint of manpower wastage and from the expenditure of money and time, to induct men unsuited for military service because of their tendency to break down with mental illness under stress and strain of military life. It was also believed that it was rare for any soldier with nervous or mental disease to be susceptible of improvement or cure by treatment in military service. Indeed, as stated in the history of the Medical Department in World War I,[1] such soldiers constantly reported at sick call, or were suddenly seized with nervous or mental collapse, or became involved in repeated military delinquencies. Moreover, while such men were ultimately discharged, they had nevertheless consumed the time and money necessary for their period of training, maintenance, and equipment in addition to the expense of their care in military hospitals. The World War I history also pointed out another unfortunate feature of inducting such men. Not only was such induction fruitless from the standpoint of obtaining an effective soldier but it was also a loss to the war effort on the homefront where, had these men been allowed to remain, they might have maintained their marginal adjustment and contributed something of value to the war effort.

From these World War I experiences and their aftermath, it seemed evident that a major objective in the procurement of large numbers of men during the mobilization period of World War II was, on the one hand, to select men who would be capable of being good soldiers and, on the other, to reject those unsuited because of mental illness or character disorder. Perhaps the most oft-quoted evidence to support such selection was the

[1] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, p. 57.

famous telegram sent by Gen. John J. Pershing, American Expeditionary Forces commander in France, to the Chief of Staff, on 15 July 1918, as follows:

> Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organizations [of] new draft prior to departure from the United States. Psychiatric forces and accommodations here inadequate to handle a greater proportion of mental cases than heretofore arriving, and if less time is taken to organize and train new division, elimination work should be speeded.[2]

For the record, however, it should be noted that the program for screening out prospective service personnel with potential psychiatric problems during World War I had been extremely variable and by no means consistent. Of the nearly 70,000 men eliminated for neuropsychiatric reasons, only 40 percent had been rejected at the time of their entrance into the Army (pp. 6–8). Faced with these facts, it would have seemed important to have undertaken new research promptly after World War I to develop methods and techniques for the collection and screening of men for a fighting Army. Unfortunately, practically nothing was done in terms of such research and very little more in the development of plans.

1939–41 PHILOSOPHY OF SELECTION

From the foregoing background data, it should be apparent that, during this period before World War II, the prevailing professional and lay opinion argued for psychiatric screening as of vital necessity to avoid the errors of World War I. This was well stated by Baganz[3] who said: "Future mobilization plans will require each draft board to include a psychiatrist." In his article, Baganz estimated that somewhat more than 1 percent of individuals examined would have some form of mental disease and that it was vital that such persons be kept out of service by some kind of screening process.

Psychiatric literature.—Other important influences supporting the philosophy of screening were the viewpoints expressed in the psychiatric literature of the time. During this period, many psychiatrists devoted considerable time and thought to the problem of psychiatric screening. One saw in their writings a rainbow of opinion, as it were, reflecting at one end an enthusiasm for psychiatric screening which overevaluated the effectiveness of such a program, believing that most of the psychiatric ills of the Army would be obviated by careful selection, shading over to the other end, reflecting a more conservative view. For the most part, writers were in a

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[2] It is noteworthy that General Pershing's request referred to a need for eliminating unsuitable personnel before oversea shipment. It made no mention of total rejection for service as seemed to be interpreted or utilized by the proponents of psychiatric screening.—A. J. G.

[3] Baganz, C. N.: The Importance of a Proper Psychiatric Survey in the Enrollment of the Personnel of Military Forces. Mil. Surgeon 86: 471–477, May 1940.

middle ground position, counseling the rejection of those who were obviously mentally unfit and, at the same time, realizing that selection would not, indeed could not, be so efficient as to obviate the breaking down of considerable numbers of men in the stress of combat, or from other strains incidental to military service.

In an excellent presentation of the problem, a Canadian Army psychiatrist [4] who had reviewed some 200 neuropsychiatric cases, in October 1940, stated: "In our estimation, the unsuitability should have been obvious in 68, or 34 percent, on enlistment." He concluded: "It is suggested that a short form of neuropsychiatric examination be part of the man's medical examination on enlistment."

That serious pyschiatrists were alarmed over the overenthusiasm of certain advocates of screening may be deduced from the following: [5]

> There may be enthusiasts who would carry psychiatric scrutiny of recruits to extremes, or who would sell to the Government infeasible mental hygiene schemes. Such promotions sometimes emanate from nonmedical sources. They tend to discredit the real service which the psychiatrist can render. That all unsuitable cases should be discovered at the beginning, no one could expect or require, nor would it be advocated that all potentially neurotic or border cases should be indiscriminately rejected. All material which can be fitted into the military organization should be utilized.
>
> Conservative opinion might be formulated somewhat as follows:
>
> 1. With adequate psychiatric instruction it should be possible for medical boards to recognize and reject on application for enlistment a high proportion of candidates who are unsuitable by reason of mental or neurological conditions.
>
> 2. Doubtful or border cases might be accepted for probationary training under special observation, their fitness or unfitness to be determined reasonably early as results of such special observation.
>
> 3. Those judged unfit during preliminary training period should be eliminated; others might be assigned to special training or duty as indicated.
>
> 4. Psychopaths as such should not necessarily be discharged from the service. They should be assigned to special duty in special units under special discipline—Spartan discipline.
>
> 5. There should be scrupulous avoidance of any attitude which would suggest or encourage the idea that minor psychiatric findings, vague nervous conditions or complaints, are grounds for rejection or discharge.

Porter,[6] in his paper, cited the cost of the care of neuropsychiatric cases from World War I, but took a moderate view as to the efficacy of the psychiatric screen imposed at induction stations. He stated:

> * * * it will probably be impossible to eliminate from the Army at either the enlistment or the training stage all soldiers who will neurotically break down under conditions of extreme combat stress. But if the examiner will scrutinize carefully and give due weight to a history of neurotic-like breakdown prior to entry into service—a large percentage of those who might develop neurosis will be eliminated.

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[4] Baille, W.: A Summary of Two Hundred Neurological and Psychiatric Admissions From the Canadian Army Service Forces. Am. J. Psychiat. 97: 753–779, January 1941.

[5] Comment: Psychiatry and the War. Am. J. Psychiat. 97: 975–976, January 1941.

[6] Porter, W. C.: The Military Psychiatrist at Work. Am. J. Psychiat. 98: 317–323, November 1941.

On the other hand, Kiene and his associates,[7] writing of their experiences in an Army induction station, said:

> Since the armistice terminating the First World War in 1918, the Government of the United States has spent approximately one billion dollars for compensation and hospital care of nervous and mental casualties suffered by our fighting forces. Many of these casualties could have been prevented by the elimination of the actual and potential sufferers from nervous and mental disease by neuropsychiatric examination at the time of their induction into the service.

Leigh,[8] writing of his experiences as a regimental medical officer in the British Army, came to these conclusions:

> There is no place in the Army for men with effort syndrome, chronic stress, dyspepsia, anxiety neurosis or anxiety hysteria, or for mental defectives. Most of these cases show a bad family history or evidence of previous breakdown, which should be detected by the civilian board and should lead to rejection. Rapid neuropsychiatric examination should be made of every recruit by an experienced psychiatrist.

Orr,[9] writing of the importance of psychiatric screening, also quoted statistics from World War I and pointed out that every three cases rejected, which would become psychiatric casualties, would save the Government $100,000 in a period of 20 years. Orr went on to say that the principal task of the local board examiner was to reject existing manifest neuropsychiatric disabilities. However, speaking of the induction board psychiatrist, he made this statement:

> With the more obviously psychopathic men eliminated, they are asked to eliminate further: (1) those men with more subtle personality disorders missed by previous examiners; (2) men whose present personality makeup suggests that they *may* break under the special stresses and strains of camp life; and, even beyond these, (3) men who may be expected to develop some type of neuropsychiatric disorder at any time during the next eleven years, the period of camp training, plus the period of liability to military service as a member of the Organized Reserve. It is even suggested that the induction board psychiatrist should endeavor to pass only men who are, in a positive sense, "vocationally suitable" for Army life, rejecting all those who, in no sense mentally ill, are nevertheless better adjusted to civilian jobs than they could ever be in the Army.

The foregoing statement summarized in brief the problems confronting the induction board psychiatrist and suggested the impossibility of completely accomplishing that which the overenthusiasts solemnly advanced as the goal of psychiatric screening.

Bowman,[10] writing on psychiatric examination in the Armed Forces, also cited the famous Pershing cablegram and the figure of a billion dollars that had been spent since the close of World War I on the care of veterans who had nervous mental disorders and pointed out that, in the last draft during World War I, approximately 2 percent of the candidates were ex-

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[7] Kiene, H. E., Hassel, A. S., and Miller, H.: Neuropsychiatric Examination at the R. I. Army Induction Station. Am. J. Psychiat. 98: 509–514, January 1942.

[8] Leigh, A. D.: Neurosis as Viewed by Regimental Medical Officer. Lancet 1: 394–396, 22 Mar. 1941.

[9] Orr, D. W.: Objectives of Selective Service Psychiatric Classification. Bull. Menninger Clin. 5: 131–133, September 1941.

[10] Bowman, K. M.: Psychiatric Examination in the Armed Forces. War Med. 1: 213–218, March 1941.

cluded from military service because of nervous or mental disease or defects and that later 3 percent more were discharged because of similar disabilities. He stated:

> With these figures in mind, it is apparent that approximately 5 percent of those chosen under the present draft either will have some neuropsychiatric disability at the time of induction or will show it shortly thereafter. The problem, therefore, from the standpoint of psychiatry is to pick out and exclude this 5 percent.[11]

Bowman then called attention to the advisory system of specialist consultation which was then being practiced; namely, a complete examination by Selective Service System examiners who, when encountering a disorder or disability which referred to a special system, such as the nervous system, referred the registrant to a psychiatrist on the medical advisory board, who then gave the draftee a complete mental examination. He believed that the first step in psychiatric screening was that of education—that it would be necessary to educate the regular board examiners to the fact that about 5 percent of all registrants were suffering from mental disorder or defect of such a degree that they should be excluded, but warned: "While men with marked feeblemindedness and clear-cut psychoses should be eliminated rather easily, it will be extremely difficult to pick out the more nearly normal persons who are sufficiently unstable mentally to make their induction undesirable."

Yet Bowman made the point that, from a study of World War I material, it had been determined that many draftees who later broke down in the service could have been "spotted" by the psychiatrist if a complete and accurate history had been obtained. He recommended, therefore, that local draft boards secure adequate social records and utilize as much as possible the files of hospitals and courts, the social service records of the community, the school records, and any material which the public health nurses might have. One of his concluding statements is significant and reflects the philosophy of taking only the best in view of the fact that a small army was being contemplated at that time:

> If an army of approximately one million men is contemplated, there is no necessity for inducting men who are not entirely qualified in every way to become good soldiers, and there is every reason for not doing so. The inductive service must not be considered a punitive measure, with its main responsibility that of preventing persons from escaping just punishment. Rather, the psychiatrist must be considered a vocational adviser, who considers carefully all of the material which passes through his hands and sees to it that only those who are vocationally fit and who will make

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[11] Quite fortuitously, the quoted 2 percent rejection rate for neuropsychiatric reasons, which was erroneously derived, agrees with the actual World War I rejection rate. The quoted discharge rate of 3 percent is grossly overstated; the discharge rate for neuropsychiatric reasons in World War I was around 1 percent. Consequently, the quoted combined 5 percent is also exaggerated. Furthermore, the quoted combined rate was obviously obtained by directly adding the rejection and discharge rates in this case—an improper statistical procedure. These rates were computed from different population bases and, therefore, are not directly additive. Even by using the quoted rejection and discharge rates, the combined rate would be about 4 percent. The correct combined rate would be about 2.8 percent. See appendix A for a comparative evaluation of World War I and World War II disqualifications and discharges for neuropsychiatric reasons.—A. J. G.

the best type of soldiers are allowed to enter the Army. In this way, the United States will have an army of high intelligence, great ability, and unsurpassed morale.

Expressing an opposite viewpoint, Kardiner,[12] on the basis of his work with patients suffering from neurosis connected with World War I, stated:

Though I have seen many hundreds of the chronic forms of these neuroses and have studied the psychopathologic picture, course, treatment, and previous personality in many cases, I should hesitate to offer any criteria that can be used to predict that a given candidate will have a traumatic neurosis.

And with what must be regarded as prescience, he went on to state:

Closely related to this question is the question whether an existing psychoneurosis of the usual type, hysteria or compulsion neurosis, is a contraindication to military service, and the answer to this is decidedly that it is not. I have seen many severely neurotic persons who were most uncomfortable and maladjusted in their premilitary life who accommodated themselves excellently to the military routine and who lost all their neurotic symptoms—for the time being at any rate.

Although Kardiner advised the rejection of men who were obviously suffering from a severe mental disorder, such as psychosis or psychoneurosis, he had this to say with regard to predisposition:

Therefore, with regard to predisposition to neurosis and fitness for service, I should rule out positively only men with a history of convulsions, tiqueurs, stammerers, and men who have shown persistent disturbances of the autonomic nervous system over a long period. These, however, can be inducted and assigned to noncombatant duties.

In the same vein, Aita,[13] writing on the basis of experience gained in examining 9,652 men at the Fort Snelling Induction Station, Minn., noted the accuracy of prognosis, as follows:

However, if examiners are to consider men carefully, they must not become too subtle through obscure reference to varied psychologic hypotheses in their establishment of prognostic data, because psychiatry is not ready for this. For the present Army, one must not attempt more than to deal with established facts and figures. It is not known how subtle or how objective the Selective Service examiners or the induction center board may become before accuracy is imperiled.

Similarly, Menninger,[14] at a seminar on practical psychiatric diagnosis for psychiatrists of medical advisory boards and Army induction boards, held in Dallas, Tex., on 16–17 June 1941, pointed out that, in Kansas, of the 17 local draft boards, 7 had general practitioners designated to serve as the "psychiatrist" on the advisory board. With this in mind, he stated, referring to Medical Circular No. 1 (p. 164), as revised:

It should be pointed out, as is done in the Circular, that it is incorrect to assume that any of the various kinds of behavior or items of personal history outlined in the examination are absolutely or definitely diagnostic of any condition in every case. Positive findings are to be regarded as suggestive, often highly and importantly so,

[12] Kardiner, A.: The Neuroses of War. War Med. 1: 219–226, March 1941.

[13] Aita, J. A.: Neurologic and Psychiatric Examination During Military Mobilization; Results and Suggestions Derived From a Study of 9,652 Men. War Med. 1: 769–780, November 1941.

[14] Menninger, W. C.: Condensed Neuropsychiatric Examination for Use by Selective Service Boards. War Med. 1: 843–853, November 1941.

of the presence of a morbid condition. Such suggested findings, can, at least, be the basis for calling the man back for more complete examination; pending this, some social investigation might be made.

ORGANIZATION OF PSYCHIATRY DURING MOBILIZATION

As early as August 1940, Dr. Winfred Overholser,[15] Superintendent, St. Elizabeths Hospital, Washington, D.C., wrote President Roosevelt, setting forth the imperative need for psychiatric evaluation of the potential serviceman. In October 1940, the Director of Selective Service, Dr. Clarence A. Dykstra, and representatives of some divisions of the War Department, met with Drs. Overholser, Harry A. Steckel, and Harry Stack Sullivan at Selective Service National Headquarters. As a result of this meeting, plans were developed to have a psychiatrist on each of the 660 selective service medical advisory boards, since it was obvious that there were not enough psychiatrists available to have one on each of the 6,403 local boards.

Dr. Harry Stack Sullivan was appointed as psychiatric consultant to Selective Service in early 1941, and an advisory board for psychiatry to the Selective Service System was appointed to aid Dr. Sullivan in developing a program. In June 1941, a psychiatrist from the Army, Capt. Philip S. Wagner, MC, was assigned to National Headquarters, to assume responsibility for the Psychiatric Section of the Medical Division of the Selective Service System, National Headquarters.

Through Dr. Sullivan's influence, a plan for the psychiatric examination of draftees was incorporated in Selective Service System's Medical Circular No. 1, issued on 7 November 1940, containing "A Minimum Psychiatric Examination of Registrants," which was designed to aid medical examiners (nonpsychiatrists) of the 6,403 draft boards in the evaluation of draftees.[16] Medical Circular No. 1 advised local board examiners to suspect the presence of neuropsychiatric problems in five categories, as follows:

Type I: Mental defect or deficiency.

Type II: Psychopathic personality.

Type III: Major abnormalities of mood.

Type IV: Psychoneurotic disorders (the hysterical; the morbidly anxious; the obsessional).

Type V: Prepsychotic and postpsychotic personalities.

The circular also advised local examining physicians to refer registrants, whose mental fitness or unfitness they could not definitely determine, to the appropriate member (psychiatrist) of the medical advisory board.

At this time, it was evident that the proponents of rigid psychiatric screening had prevailed, as witness the following statement of Dr. Dykstra, in his letter of 7 November 1940, to which was appended Medical Circular No. 1:

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[15] Overholser, Winfred: Early Steps in Psychiatric Mobilization. [Unpublished manuscript.]

[16] Physical Examination of Selective Service Registrants. Special Monograph No. 15. Volume II. Appendices D–E. Washington: U.S. Government Printing Office, 1948, pp. 92–96.

Military life requires that the soldier shall be able to live comfortably in continued close contact with a variegated group of other men. He cannot depend on any self-evolved protective mechanism that sets him apart from his fellows. Military and naval experience is in favor of excluding from the Armed Forces all persons discovered to have mental or personality handicap of any material degree.

With the beginning of the draft in November 1940, all candidates were examined by physicians in their own communities. These local examiners had the authority to reject those men whom they believed were not qualified to meet the standards set forth in mobilization regulations. Registrants found to be fit were then referred to the nearby Army induction station for a second complete examination (including psychiatric evaluation) which determined final acceptance or rejection for service.

Indoctrination of Psychiatrists

In order to orient psychiatrists in their function at the local board level or at the Army induction station, a program was planned for a series of seminars to be conducted in various parts of the country. This program was developed to a large extent as a result of the initiative and stimulation of Dr. Sullivan. Eventually, a series of 2-day seminars were held in nine large cities in the country for the medical advisory board and Army induction station psychiatrists.

The first of these seminars, held in Washington, D.C., on 2–3 January 1941, was designed to be a kind of pilot program which could then be utilized for subsequent programs throughout the country. The second was held in Boston, Mass., on 30–31 January 1941; and the third, in Atlanta, Ga., on 5–6 February 1941. Others which followed were held in New York, N. Y., on 5–6 April; in Chicago, Ill., on 19–20 May; in Dallas, Tex., on 16–17 June; in Los Angeles, Calif., on 19–20 June; in San Francisco, Calif., on 20–21 June; and in Buffalo, N.Y., on 21–22 July.

The attendance of selective service psychiatrists of 45 States and the District of Columbia was authorized. Corps area commanders were encouraged to facilitate the attendance of psychiatrists working with Army induction stations. All members of the American Psychiatric Association, or physicians designated as interested in neurology, neuropsychiatry, or psychiatry by the American Medical Association, were invited. Of the 584 physicians serving as psychiatrists on medical advisory boards, 312 participated in at least one of the seminars. At least 106 of those in attendance indicated that they were serving at least part time on some Army induction board.

The first day of each seminar was organized to include as essential features a presentation of military psychiatry, the experience of the Veterans' Administration in providing medical care and other benefits for those who had served in World War I, and an outline of the practical diagnostic possibilities and procedures which could be used to exclude from induction

a considerable proportion of those who would probably become psychiatric casualties.

The first day's presentation on military psychiatry was handled by Medical Corps officers, Lt. Cols. William C. Porter, Patrick S. Madigan, or George E. Hesner. Drs. Martin Cooley, John H. Beard, Harry H. Rubin, William A. Jones, Percival G. Lasche, or Neathe V. Bolen spoke for the Veterans' Administration. Dr. Harry Stack Sullivan handled the session on practical diagnosis.

On the second day of each seminar, a group of outstanding specialists discussed diagnostic procedures and implications pertaining to registrants' falling within the various groups as outlined in directives from the Office of The Surgeon General and the Selective Service System.[17]

The Army Medical Corps and Veterans' Administration representatives actively participated and added greatly to the enthusiastic discussion by psychiatrists of the selective service and Army induction boards. Evening sessions were devoted to problems of local board examining physicians. An especially distinguished contribution in this connection was made by Dr. C. Macfie Campbell [18] at the Boston seminar. His talk was reprinted and 18,000 copies were distributed throughout the Selective Service System.

By the end of July 1941, the nine seminars were concluded, and the first phase of the psychiatric program for military mobilization was completed.

Concepts Developed

In early 1941, it was fairly well assumed by various psychiatrists that those factors which might identify the potential neuropsychiatric casualty were known. Furthermore, at this time, military plans called for an army of approximately 1 million men to be a well-selected nucleus of personnel for the Military Establishment, which could, after a period of training, be placed in reserve and returned to active duty if the need arose.

In such circumstances, it seemed not unreasonable to err on the side of rejecting a fairly large number of men who might not become neuropsychiatric casualties in order to eliminate the largest percentage of potential problems. At the seminar held in Washington, D.C., on 2–3 January 1941, this viewpoint was stated: "The effect of mental diseases on a militarized individual is different from that on the same individual in civil life. Military training intensifies the defects of weaklings instead of 'making men out of them'." The philosophy expressed was that service-aggravated conditions are a loss to the State and to the individual as well as to the service:

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[17] (1) Circular Letter No. 19, Office of The Surgeon General, U.S. Army, 12 Mar. 1941. (2) Medical Circular No. 1, Selective Service System, 7 Nov. 1940 (revised 19 May 1941).

[18] Campbell, C. M.: Selective Service and Psychiatric Issues. J.A.M.A. 116: 1883–1887, 26 Apr. 1941.

Since the Army cannot promise any soldier what job he is to have, and since the service is now highly mechanized, great emotional stability is required of conscriptees. Low-grade morons are entirely unsuitable! Peacetime disabilities in the Army with no service history at all amounted to 33,440, of which 20 percent, 6,638, had diseases of nervous system. One-half of those receiving treatment from Federal facilities throughout the country were psychoneurotics * * *. The great value of a social history of the registrant before examination would require that records of organized welfare groups of the Red Cross and so forth be opened for inspection by local and medical advisory boards.

Psychopaths are those vocationally unfit for service and include the eccentric, the leader in subversive activities, the emotionally unstable, the sexually perverse, those with inadequate personalities that do not adapt readily, and those who are resentful of discipline. All are not assimilable in service. The inability to escape from circumstances over which they have no control causes explosive behavior which disappears as soon as they are restored to their homes. The aggressive type also shows up within this group. He stands monotony and discipline poorly. The passive type and those having mood disorders are not suitable to the teamwork which is necessary in modern training in warfare. The psychiatrists of the medical advisory boards would expect to have referred to them for further examination 5 percent of the number of registrants in each locality not definitely recognizable as belonging to the type of unfit enumerated in Medical Circular No. 1.

This, then, was the general thinking expressed by psychiatrists, by the Selective Service System, and by the military service as it became apparent that war was imminent.

Albeit the aforementioned reasons for psychiatric screening appeared valid, nevertheless one heard them quoted ad nauseam and repeatedly used as a "cliche" to rationalize the tendency of examiners to reject not only those who were obviously unfit but also those who were thought to possess a predisposition to mental disease. Since the great shortage of manpower was not experienced until later in the war, the philosophy of skimming off the cream—"when in doubt reject"; "if we're building only a small Army let's make it of the best men available"—appealed to line officer and medical examiner alike. In induction stations, one not infrequently heard the remark when considering whether or not to reject a registrant, "if there is any doubt, reject him, there'll be another better one along in a few minutes." Thus, as a result of this concept and procedure, many registrants were screened out, who, later upon reexamination, were inducted and subsequently made excellent service records.[19]

Disagreement

Some exception to the program planning and to the various categories of individuals who should be excluded from service was taken by a number of psychiatrists and was voiced by one of the authors (R. W. W.) to Col. Leonard G. Rowntree, Chief of the Medical Division, Selective Service System, National Headquarters, 27 January 1941, as follows:

[19] Eagan, J. R., Jackson, L., and Eanes, R. H.: A Study of Neuropsychiatric Rejectees. J.A.M.A. 145: 466–469, 17 Feb. 1951.

In view of the large number of Draft Boards and the relative scarcity of psychiatrists, it would seem to me that the screen should perhaps be as fine as suggested in Medical Circular No. 1 for the local draft boards, *but most certainly not for the psychiatrists of the Medical Advisory Boards.* The men thus selected (at the local board level) as having some deviation should be referred to a psychiatrist of the medical advisory board. The psychiatrist should be allowed to use his own judgment in determining the fitness of a man for service. I am convinced that many men will be unjustly treated if fixed categories, such as included in Medical Circular No. 1 are used to automatically exclude a man for service * * * psychiatric patients might make far better than average soldiers if they would not be more or less automatically excluded because they had received psychiatric treatment * * *. There are persons who could easily pass the examining boards who would undoubtedly make a poor adjustment as a soldier. It boils down to the fact, then, that the examining psychiatrist must use his own judgment in a large degree to determine those who are psychiatrically fit or unfit for service * * *. The history of his school, work, and social adjustment is far more important than is evidence of tension during a medical examination.

The warning expressed in this letter and similar comments from a number of other psychiatrists received relatively little attention, as is so strongly emphasized in the reply written over Colonel Rowntree's signature, dated 3 February 1941:

True, none of us can be sure that very grave demands on American manpower may not be made in the future. There is no such emergency in immediate prospect, however, and even if there were, the major characteristics of total warfare would probably indicate much the same policy as that now in force * * *. It is equally evident that we cannot depend solely on the undirected judgment of any particular psychiatrist to select those who will be inducted. It is perhaps reckless to try to induct people with great ability associated with unusual personality. A consideration of best untilization seems to indicate their finding a place elsewhere in the total defense picture.

PHYSICAL AND MENTAL STANDARDS

Mobilization Period

As the Army first began to build up, the physical standards which were to be applied for selective service registrants were contained in MR (Mobilization Regulations) 1–5, dated 5 December 1932. (See appendix B, pp. 775–777). The standards of physical examination subsequently set forth in Selective Service Regulations (physical examination) were identical with those prescribed in MR 1–5, even to the numbering of the paragraphs and sections. MR 1–5 was to be used during any mobilization for which selective service was planned; also, it was to govern the retention or discharge of members of the National Guard drafted into Federal service and the acceptance or rejection of applicants for voluntary enlistment before the operation of selective service, with certain exceptions. One of the exceptions was that "no applicant for voluntary enlistment whose mental age is less than ten years will be accepted. Any member of the National Guard whose mental age is found at the time of being drafted into the Federal service to be less than ten years will be discharged."

On 31 August 1940, MR 1–5 was superseded by MR 1–9 (appendix B, pp. 777–782). These were the mobilization regulations which governed at the time selective service registrants were first called for examination and induction into the Army of the United States. Changes in standards which occurred with the publication of MR 1–9 were as follows:

Under MR 1–5, men having hysterical paralysis or hysterical stigmata and local muscular spasms "which do not cause mental or physical defects disqualifying for general military service" were acceptable as general or unlimited service. This qualification for general service was deleted in the August 1940 edition of MR 1–9. Similarly, whereas MR 1–5 allowed the induction for limited service of men with hysterical paralysis or hysterical stigmata "of a degree disqualifying for general military service, but not of a character to prevent the registrants from successfully following a useful vocation in civil life," the edition of MR 1–9 deleted this qualification for limited service. Drug addiction was another condition which under MR 1–5 was acceptable for special or limited service but which was deleted in MR 1–9.

As previously stated, Selective Service Medical Circular No. 1 provided guidelines and standards for local draft board physicians and their advisory psychiatrists relative to psychiatric criteria for selection or rejection. Before the publication of The Surgeon General's Circular Letter No. 19, in March 1941, there had been a considerable hiatus between the standards underlying the Selective Service psychiatric screen and the Army induction screen. Selective Service physicians, following their Medical Circular No. 1, were using an implied standard that was more general than the seemingly rigid and specific criteria, established by section IX of MR 1–9, which guided psychiatrists of the induction stations.

Circular Letter No. 19 brought the expressed and implied standards of the induction stations into substantial agreement with selective service standards; thereupon, the Selective Service System revised its Medical Circular No. 1, on 19 May 1941,[20] to remove any possibilities of divergence of views between the two groups of psychiatrists and other physicians by enlarging group IV to include so-called psychosomatic disorders and by adding three other groups; that is, chronic inebriety, syphilis of the central nervous system, and other organic neurological disorders.

Before this report was accomplished, however, a radical remedy had been suggested for the dissatisfaction which was growing in the country at large over the high rate of rejections at induction stations. It was then proposed that there be a joint Army-selective service examination. In some of the great cities, for instance, real bitterness existed over the rejection at the Army induction station of those selectees believed by the local boards to be malingering. Forgetting that the question of malingering was one which had been brought up at seminars repeatedly and had been

[20] Physical Examination of Selective Service Registrants. Special Monograph No. 15, *op. cit.*, pp. 96–102.

discussed thoroughly, many men brought forth the accusation that malingering to evade duty by affecting symptoms of a mental disorder were the result of these seminars and the publicity attendant thereupon. These accusations were made despite general acceptance that the first increment of selectees would become the source of many officer and noncommissioned officer leaders for the subsequent expansion of the Army should it become necessary, and therefore, it was imperative to enforce high standards of physical and personal as well as mental fitness. Moreover, it was obvious that, should this country become involved in war, it would become necessary to enlarge the Army rapidly, building upon the nucleus obtained through selection and voluntary enlistment during the early days. For this reason, the philosophy of accepting only the cream and rejecting those who not only were obviously unfit, but also those who might be classified as borderline, continued to be that which governed in the minds of most examiners.

Viewed historically, it is probable that this philosophy was a healthy one [21] and did indeed result in providing a nucleus of physically and mentally fit and alert young men upon whom later developed the tremendous responsibilities of rapidly enlarging and training an army for severe combat.

Wartime Period

With the onset of war, acceleration of the draft, and continued dissatisfaction with the dual system of medical processing of registrants, local draft board examination by Selective Service physicians was abandoned in favor of a single routine complete examination at the induction station; not, however, without a good deal of controversy and recrimination and with the resignation of Dr. Sullivan as psychiatric consultant to Selective Service.[22] Also, physical standards for induction, including the psychiatric and neurological criteria, were changed and, subsequently, underwent repeated revisions as the war progressed, in response both to the need to eliminate errors found by practical experience and to the demands based upon manpower availability.

In addition, the War Department, from time to time, issued instructions relative to the interpretation or application of the standards then in effect. Such instructions were obviously a reaction to manpower needs, at the particular time; difficulties in the assignment and utilization of limited-service personnel; shortages of psychiatrists; and the rise and fall of the tides of war. These instructions also corrected obvious errors but, at times, would completely reverse instructions issued only several weeks previously. On such occasions, induction examiners, including psychiatrists, were under-

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[21] Unfortunately, a precedent was provided and values for mental health were established which were not susceptible of radical change with the onset of war and the need to develop rapidly large military forces from the available manpower resources.—A. J. G.

[22] (1) See chapter I, p. 22. (2) Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 269–270.

standably confused and exasperated in their efforts to develop and maintain a consistent professional viewpoint toward selection for military service.

First revision

The first revision of MR 1–9 was issued on 15 March 1942. In general, the new edition tended to liberalize previous standards for induction, no doubt to facilitate the raising of a large wartime army. The revision included a separate section (XIX) on neurological disorders, in which methods of examination were described and a class of individuals possessing a neurological disorder was made acceptable for special or limited duty; namely, "* * * those who present muscular tremors or local paralyses due to old poliomyelitis or nonprogressive disease of the spinal cord or peripheral nerves of such marked degree that they disqualify for general military service but have not prevented the individual from successfully following a useful vocation in civil life." Diagnostic criteria for disqualifying neurological defects were described briefly.

The section on mental disorders was revised and entitled "Psychoses, Psychoneuroses, Personality Disorders" (section XX). A routine procedure for examination was described, and the minimum psychiatric examination was outlined. A significant change in acceptability for class 1–A, or general military service, was that men of "marginal intelligence, if compensated for by better than average stability" were, for the first time, made acceptable for general military service. Likewise, whereas the first edition of MR 1–9 accepted for only limited service those who had stuttering and stammering to any material extent, such disorders were now placed in the acceptable category for general military service, as follows: "Men whose speech can readily be understood, even though there is a moderate degree of stuttering or stammering, if otherwise physically, intellectually and emotionally fit." It made acceptable for limited service those possessing "moderate degrees of compulsiveness or obsessiveness."

The paragraph entitled "Diagnostic Criteria" was enlarged considerably, and more adequate descriptions were included. The psychopathic personalities were described and defined. The old subheading "Manic-Depressive Insanity" was revised and entitled "Major Abnormalities of Mood." Psychoneurotic disorders were described for the first time, and criteria for acceptance and rejection were given. It is interesting to note that the first edition and all successive editions of MR 1–9 continued to reject unconditionally drug addicts.

Changing instructions

On 1 August 1942, The Adjutant General, in a radiogram to all service commands, stated that, because of the extreme difficulty which selective service was experiencing in filling its quotas, it directs "active medical

supervision of Army examining boards at recruiting and induction stations to the end that no individual physically qualified for general military service is rejected for physical reasons."

On 11 August, another radiogram was dispatched to all commanding generals of service commands. In this radiogram, instructions were given that the standards for acceptance for induction as prescribed in MR 1–9 would be considered by the examining personnel as a guide to their discretion and would not be construed strictly or arbitrarily. The radiogram further stated:

> The possibility that some individual soldiers may have to be discharged for disability or that others may eventually make claims on account of disability is of minor importance compared to necessity of immediately inducting the maximum number of qualified registrants into our wartime Army.

MR 1–9 was again revised without any particular changes, and the new edition was issued on 15 October 1942. Nevertheless, on 22 October 1942, only 1 week later, another radiogram rescinded the instructions on standards for acceptance as set forth in the radiogram of 11 August and substituted the following:

> The objective of MR 1–9, standards of physical examination during mobilization, is not only to procure men who are physically fit for the rigors of general military service or limited service, but also to avoid burdening medical facilities with unqualified personnel. Examining personnel will consider these standards as a guide, to be followed with discretion without arbitrary adherence to technicalities. The examination will be carried out with the utmost care in order that no individuals who are obviously unfit for service will be accepted, only to be discharged within a short time on certification of disability.

This succession of radiograms, uncorrelated with the changes of MR 1–9, with conflicting instructions and ambivalence of intention and meaning could only be due to a lack of coordination between line officers in the War Department and those in the Surgeon General's Office. For instance, it is likely that the radiogram of 11 August was dispatched without prior clearance with the Surgeon General's Office and the radiogram of 22 October, 2 months later, was dispatched because The Surgeon General, having learned of the 11 August instructions, succeeded in having them rescinded. The lesson here is plain—staff action and directives from the War Department must be correlated with all interested agencies.

Later revisions

On 22 January 1943, Changes No. 1 of MR 1–9 were issued. This revision reflected a conservative trend consistent with the instructions of 22 October 1942 and, apparently, was a reaction to the increasing number of neuropsychiatric problems that were appearing at the various camps. Changes No. 1 rescinded the acceptance of individuals for limited service with local paralyses due to old poliomyelitis, or nonprogressive dis-

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ease, which had been established in the October 1942 revision of MR 1–9, stating: "There are no neurological disorders which warrant initial selection for limited service." Likewise rescinded was paragraph 91a, which formerly made acceptable "moderate degrees of compulsiveness or obsessiveness." In the same vein, before Changes No. 1, bed wetting was not considered to be a psychiatric problem and was not a cause for unconditional rejection. According to the previous edition of MR 1–9, "men claiming to be bed wetters may be placed in class 1–A unless enuresis is substantiated by physician's affidavit, or other acceptable documentary evidence." Changes No. 1, however, made a more final statement: "Bona fide enuresis substantiated by physician's affidavit or other acceptable documentary evidence is cause for unconditional rejection."

Another revision of MR 1–9 issued on 19 April 1944 continued the conservative viewpoint. There were no material changes in standards for psychiatric examination as described in section XXI. Minor changes, however, were made in terminology. For example, instead of designating major abnormalities of mood and prepsychotic, postpsychotic, and other schizophrenic disorders as separate entities, the new revision included these under a single head; namely, psychosis. Instead of "psychoneurotic disorder," the new edition utilized "psychoneurosis."

This revision considered certain behavior disorders to be nonacceptable, as follows: "Primary behavior disorders of sufficient degree to indicate predisposition to more serious disorders." The subparagraphs of "Diagnostic Criteria" were further revised and enlarged, and a description of primary behavior disorders with a breakdown of the various types, such as simple adult maladjustment, neurotic traits, enuresis, emotional immaturity, and stammering and stuttering, were included for the first time.

Also, for the first time, MR 1-9 contained a section on intelligence (XXII). Under "General Service," the following statement was made:

> Individuals who are graduates of standard English-speaking high schools are acceptable. Individuals who are not graduates of standard English-speaking high schools will be given prescribed objective tests of intelligence. A man achieving the critical score, or a higher score on one or more of the authorized tests is acceptable for induction.

Under the heading "Limited Service," it was stated: "There are no intelligence criteria to warrant initial selection for limited service." Under "Nonacceptable" was stated:

> Failure of a nongraduate of a standard English-speaking high school to achieve a score in one or more of the prescribed tests equal to or higher than the critical score will be accepted as evidence of low intelligence. Such persons are nonacceptable.

Some liberalization was made in neurological disorders. Under section XX, it was again provided that men with "local paralyses such as due to poliomyelitis or nonprogressive disease of peripheral nerves * * *" were again made acceptable for limited service.

Experience Induces Liberal Trends

With over 2 years of wartime experience and with the accumulation of reports and observations from training centers, oversea garrisons, and combat divisions, a gradual but surprising optimistic change in philosophy occurred relative to the ability of the ordinary individual to withstand stress and strain. It has been frequently observed that times of stress are apt to produce a leveling effect as far as man's thinking is concerned. The conviction that it was a man's job to fight until he could fight no longer grew in the minds of both line officers and medical officers. Also, at this time, there was an acute shortage of manpower, and it became increasingly more apparent that a larger proportion of draftees than hithertofore would have to be inducted. It also became known that the exhibition of nail biting, tremor, and "nervousness" did not necessarily indicate that a person with such traits or signs could not fight effectively or that he could not serve effectively in some noncombat capacity, either in the Zone of Interior or in a communications zone. Therefore, as evidence began to accumulate that many individuals with minor symptoms could be of service in the Armed Forces, this newly acquired knowledge was conveyed to induction station examiners and others concerned with screening procedures.

War Department Technical Bulletin (TB MED) 33

This information, therefore, was published in TB MED 33, "Induction Station Neuropsychiatric Examination," and issued on 21 April 1944.[23] In this bulletin, it was pointed out that, from accumulated evidence, many individuals with minor personality defects and neurotic trends could be of service, but that it was believed that, on the basis of previous directives sent out from the War Department, many such men were being rejected at induction stations on neuropsychiatric grounds. Attention was called to the acute need for manpower with the subsequent necessity of admitting all individuals into the Armed Forces who had a reasonable chance of adjusting to the service. It emphasized that the neuropsychiatric study "should be made on a longitudinal basis and not on a cross section" because from observations on inspection tours and information garnered from various sources, the Surgeon General's Office was aware that many rejections were being made after a short examination, which consisted in many instances of leading and suggestive questions, such as "Do you worry?"

[23] It is noteworthy that TB MED 33, which laid down liberal guidance for screening, was issued only 2 days after the publication of a revision of MR 1–9 (p. 168) which continued the previous conservative trend. Clearly, information for technical medical bulletins originated in the Office of The Surgeon General, and no doubt, TB MED 33 reflected the work of Menninger and his associates in the Neuropsychiatry Consultants Division of the Surgeon General's Office. Apparently, the Neuropsychiatry Consultants Division took this technical means of bringing about realistic guidance to induction station examiners after having failed to influence the staff agency responsible for the 19 April revision of MR 1–9. It should be further noted that TB MED 33 superseded previous guidance by stating: "Previous directives in conflict herewith are rescinded."—A. J. G.

"Are you nervous?" or "Do you have headaches or stomach trouble?" It pointed out that such an examination was inadequate. Attention was focused on the fact that rejection for neuropsychiatric reasons "should be made only in those cases in which the history and examination clearly indicate the existence in the past and/or present of a personality disorder of partially or completely incapacitating degree." Further, it pointed out that an individual's normal concern over the prospect of induction, as manifested by moderately moist palms or tenseness, should not be regarded as evidence of such an incapacitating disorder.

The bulletin further stated that information and time were often inadequate to establish an accurate diagnosis and that, in many instances, the symptomatology or behavior, or both, although not sufficiently well crystallized to warrant the diagnosis of a clinical disease entity, might make disqualification of the registrant necessary. Thus, labeling a registrant with a diagnostic term in so brief an examination without adequate data available was unscientific and unfair to the individual. It directed, therefore, that each clinical diagnosis as outlined in MR 1–9 would be based on adequate historical and examinational evidence. Further, that in those instances "where insufficient data are available to arrive at a diagnosis and where it is the neuropsychiatrist's considered opinion that the registrant is not acceptable, he will indicate that the individual is disqualified as 'not suited for military service,' " amplified by some qualification, such as "due to severe antisocial tendencies" or "due to severe neurotic symptoms." Thus, although the primary purpose of the neuropsychiatric examination would be served, that is, rejecting those not fitted, the registrant would not receive a stigmatizing label which might prove embarrassing to him upon his return to his community or his job.

Results of TB MED 33

That TB MED 33 had, to a certain extent, the desired effect in reducing the rejection rate and in making available for induction more men who were capable of becoming soldiers was evidenced by both statistics and comments by interested official observers. An example of this was the survey of registrants, previously rejected for psychiatric reasons, conducted at the Armed Forces Induction Station, Fort McPherson, Ga., on 12 June 1944. The investigators of the survey commented that it was apparent in the instructions in TB MED 33 that some relaxation in the rather severe standards heretofore followed was indicated. They also stated:

> Upon receipt of news of the contents of this bulletin, the chief medical examiner and the psychiatrists at the induction station, Fort McPherson, felt that many men previously disqualified for psychiatric reasons might be salvaged for military service. * * * volunteered to reexamine a group of 50 such registrants, but only 25 were forwarded for reexamination. Of this number, over 50 percent were found acceptable. * * * again volunteered to reexamine a larger group.

In the larger group, consisting of 732 Georgia registrants previously disqualified for psychiatric reasons, 413 were found acceptable and 319 were again rejected. This was an example that, with a change in philosophy and with adequate direction to the field, a larger number of men previously thought to be disqualified could have been obtained for service.

After this survey, a study was made at the Detroit Armed Forces Induction Station. A total of 248 men who previously would have been rejected as borderline cases were accepted for service. The status of these men was determined 12 months after induction. At that time, 209 of the 248 were still on duty; 32 had been discharged; and 5 had died in the service. It is interesting to note that two were discharged to accept commissions as officers.

Later changes

On 8 September 1944, Changes No. 2 of MR 1–9 were issued. These changes again were of little moment and only provided for a neurological examination to detect late complications of syphilis and a spinal fluid examination for such cases. Further, that each individual requiring such a spinal fluid examination would be hospitalized for that purpose as authorized in another section of the regulations.

Because verbal instructions issued in 1944 (p. 222) were misinterpreted by induction station examiners and authorities to mean that emphasis was now being placed on the rejection of inductees, clarification was considered necessary. Accordingly, on 18 December 1944, a radiogram was dispatched to the commanding general of each service command and to the oversea departments. This radiogram stated:

> It is the intent of the War Department that emphasis be placed on the acceptance of men who meet the requirements of MR 1–9 for general service. * * * The medical examination personnel of Armed Forces Induction Stations will be cautioned to follow carefully the provisions of MR 1–9 for general military service and to consider acceptable any man who meets those physical requirements. * * * Any enlisted men who, after being profiled at the reception center is considered below minimal physical induction standards for limited military service as prescribed in MR 1–9, will not be discharged, but his physical profile will be confirmed by a board of three medical officers appointed by the post commander. Those found below profile C will be assigned to the nearest ASF [Army Service Forces] training center for which best qualified, unless designated by current instructions for training at a special training unit, or unless the medical board finds that the defect is progressive or likely to be aggravated by military service. In the latter case the individual will be hospitalized for consideration for discharge under the provisions of AR 615–361.

Final revision

After the cessation of hostilities in Europe, and with the end of the war clearly in sight, the last wartime revision, that is, Changes No. 3 of MR 1–9, was issued on 4 June 1945. This revision finally incorporated not

only the instructions laid down in TB MED 33 but also other hard-won lessons learned by World War II psychiatrists and provided comprehensive and practical guidance for psychiatric screening. The change consisted almost exclusively of a revision of the entire section XXI (Psychoses, psychoneuroses, personality disorders). Herein was stated that the primary object of the psychiatric examination was to procure men who were without psychiatric disorders of such a degree of severity as to make impossible their rendering effective military service. Again, following the principles of TB MED 33, the ideation expressed was that of acceptance, rather than that of rejection, with emphasis upon accepting as many men as possible who would make effective soldiers. Also stressed again was that acceptance or rejection should be based not only upon the findings present at the time of examination but also upon the careful consideration of the longitudinal history of the registrant and the absence of previous maladjustment, as follows:

> Attention will be given not only to unfavorable or negative data in the history, but also to the favorable or positive data, since the history of good adjustment in the past may be reasonably accepted as favoring a good adjustment in the military service as well.

For the first time, the category of chronic psychoneurosis was made acceptable for limited service. Likewise, acceptable for limited service were moderate transient psychoneurotic reactions. Also acceptable for the first time were mental deficiencies, mild in degree, as manifested by completion of the fourth grade in school, unless prevented by external circumstances, if there was evidence of ability and stability in the home, in the community, and at work.

Guidance in the area of primary behavior disorders was clarified as follows: In the last previous edition of MR 1–9 (19 April 1944), it was stated that such disorders may or may not be cause for rejection, depending upon their severity, followed by: "They are cause for rejection either because they indicate predisposition to more serious mental disorder, or because the symptom itself interferes with military efficiency." Changes No. 3 read as follows: "They are cause for rejection if it is considered that the symptom itself will interfere with the performance of effective military service." Thus, attention was focused sharply on the problem at hand; namely, that of obtaining effective soldiers and not upon rejection.

Following in this enlightened vein, as in TB MED 33, Changes No. 3 provided that, because of time limitations or when information was often inadequate to establish accurate diagnoses, to label a registrant with a diagnostic term in so brief an examination, without adequate data available, was unscientific, and unfair to the individual. Thus, psychiatrists were enjoined to—

> * * * carefully avoid unscientific methods which give inadequate or inaccurate data. Thus, a neuropsychiatric examination consisting of a few leading and suggestive questions, such as "Do you worry?" "Are you nervous?" or "Do you have headaches or

stomach trouble?" is inadequate, and positive answers to such questions are not in themselves justifiable cause for rejection. Isolated signs, such as nail biting, slight tremor, or vasomotor symptoms, are not disqualifying.

Further, as also contained in TB MED 33, in those instances where insufficient data were available and where the neuropsychiatrist deemed the registrant not acceptable, the examiner would indicate that the individual was disqualified as "not suited for military service." The clause "not suited for military service" would then be amplified by one of several qualifications (p. 170).

Shortage of Psychiatrists

By the end of 1942, the shortage of psychiatrists was beginning to become a matter of urgency. Psychiatrists were especially difficult to secure for outlying induction stations not near enough to a center of population to draw upon civilian specialists in psychiatry. In order to make the most economical use of the time of the psychiatrists attached to these induction boards, a radiogram from The Adjutant General was dispatched on 7 December 1942 to the commanding general of each service command, of the Hawaiian, Panama, and Puerto Rican Departments, and of the Alaska Defense Command. This radiogram instructed these officers that, where sufficient psychiatrists to examine all inductees were not available, the lack of psychiatric examiners would be overcome by utilizing medical examiners to sift out suspected mental cases for detailed study by available psychiatrists, instead of the latter attempting abbreviated examinations of all inductees. It further directed "additional and continuous effort will be made to obtain the required number of psychiatrists at each induction station."

Navy Participation

When the Navy could no longer obtain sufficient recruits by voluntary enlistment, it was determined to conduct joint Army and Navy inductions. On 9 January 1943, by airmail, a notice of such intent was sent to the commanding generals of all service commands, of the Puerto Rican and Hawaiian Departments, and of the Alaska Defense Command, stating that such plans were underway and that operation would begin on 1 February 1943.

On 22 January 1943, detailed instructions were mailed to the commanding generals of all the service commands on the subject of joint induction procedure of the Army, Navy, Marine Corps, and Coast Guard. The joint operation did not materially affect psychiatric examiners or standards. However, the psychiatric personnel problem of the induction stations was aided materially by this joint operation inasmuch as the Navy furnished 20 percent of the personnel of these stations, supplying 48 psychiatrists for duty in induction centers about 1 February 1943.

Because the Navy had always maintained a more rigid and more exacting standard for enlistment than had the Army for either enlistment or induction, Navy psychiatric examiners were prone to reject many more registrants than were Army psychiatrists, as a general rule. It was necessary to visit various induction stations and secure the cooperation of all the psychiatrists in trying to establish uniform criteria. In a few instances, it was necessary to request that certain examiners of both branches of service be transferred to other assignments, because of their unduly high rejection rates.

Correction of Neuropsychiatric Statistical Reporting

In evaluating the statistical data relating to the neuropsychiatric rejections, it must be realized that certain preferential procedures obtained with respect to reporting, on the monthly report, primary disqualifying causes. When more than one medical disqualifying cause was present, one of which was a neuropsychiatric cause, the procedure called for reporting the neuropsychiatric disorder as the primary disqualifying cause in preferance to the other medical disqualifying cause(s). Thus, upon compilation of statistics, the psychiatric disorder was found to be listed as the primary cause for rejection, and accordingly, the psychiatrist appeared to be responsible for the greatest number of rejections even though many were actually joint rejections; that is, rejections also for some other defects. Often, these other irremedial defects were found simultaneously but were given a number two spot on the rejection statement.

In order to bring statistics into a more equitable relationship, on 4 November 1943, a letter was dispatched to the commanding generals of all service commands, as well as to departments overseas, on the subject of listing of disqualifying defects of rejected registrants. In short, this directive instructed that all defects found would be reported fully and accurately on the report of physical examination. Furthermore, that "defects would be listed in the summary of the physical examination in the order of their importance." It was specified that the "irremediable, disqualifying permanent defects should be listed as #1 and the others in order of their importance." It was specifically directed that the principal defect should be that which was most permanent and irremediable. It is believed that this action resulted in a fair statistical report insofar as it did something to equate psychiatric rejections with other types of rejections.

Procedure for Suspect Cases

Frequently, registrants, reporting for induction and later for preinduction examinations, would state that they had some disorder which was disqualifying but for which there were no subjective symptoms or discernible signs. For instance, a man would state that he was an "epileptic"

or an "enuretic." Frequently, such men were rejected upon their statements, and in many instances, it was later determined by the local board of the Selective Service System that the registrant had malingered and had misrepresented facts or through ignorance had given a diagnosis which was not substantiated by any reputable physician.

On 27 November 1944, a letter from The Adjutant General's Office, on preinduction physical examination and induction of registrants, was sent to the commanding generals of all the service commands and to oversea departments. This letter provided that no registrant would be rejected upon his own unverified statement of a disqualifying disorder or defect, but that he would be rejected only if documentary and substantiating evidence were provided at the time of the examination. Further, that registrants, previously accepted at the time of preinduction examination, who upon presenting themselves for induction presented documentary evidence of a disqualifying disorder or defect, would be rejected only if the disorder was substantiated by objective signs or when such documentary evidence had been forwarded with the records by the Selective Service local board, or after the local board had been given an opportunity to verify or refute such evidence. It also stated that, if such evidence was provided and it was not substantiated by objective signs, the man would be held over for a period not to exceed 3 days in order that such evidence might be verified or refuted through the local board by telephone or telegram. Then, if at the end of a 3-day period, verification had not been received through the local board, the registrant would be allocated to the Army or Navy and inducted.

PHYSICAL PROFILE SERIAL SYSTEM

As the war progressed, it became apparent that it would be extremely helpful in the utilization of available manpower to develop a method of physically classifying individuals according to their functional capacities. Such a method, the "Physical Profile Serial," issued on 22 May 1944, was devised and published as a supplement to MR 1–9. The Physical Profile Serial was patterned on the PULHEMS System which had been developed in the Canadian Army and which represented functional capacity, as follows:

P: General bodily functions, including the various major physical systems of the body, such as cardiovascular, respiratory, and genitourinary.
U: Upper extremities.
L: Lower extremities.
H: Hearing.
E: Vision.
M: Intellectual capacity.
S: Emotional stability.

In the American version, *M*, or the intellectual factor, of the serial

was deleted, leaving the letter *S* to represent all neuropsychiatric factors, including emotional stability, intelligence, personality, and mental illness or defect, if present. In concept, PULHES was based primarily upon a numeral scoring of the functions of the various organs and bodily systems. Under all categories of PULHES, with the exception of *S*, a numeral scoring from 1 to 4 was utilized, the numeral 1 representing normal function and the numeral 4 representing below minimum standards for induction. For the psychiatric factor, *S*, numeral 2 was omitted. To obtain ease of application, the first two numeral ratings were equated with a high level of physical and mental fitness and thus represented the general military service category. Numeral 3 identified individuals with defects which prevented the individual from being classified for general military service, but which considered the person acceptable for limited service. Numeral 4 represented incapacities that were below minimum physical or mental standards for induction.

The PULHES supplement of MR 1–9, issued on 22 May 1944, stated that the initial profile would be accomplished by medical officers at the reception center from the physical inspection which was required for all new personnel reporting to the training camp. The information concerning the upper and lower extremities and the visual and auditory acuity could readily be obtained and transcribed from the DSS Form 221 (Report on Physical Examination and Induction), which form accompanied the inductee to the reception center. It was not intended that the special examination would be repeated at the reception center level, other than in the exceptional cases. It was to be understood that if a registrant successfully passed the induction station examination he was neuropsychiatrically acceptable as class 1. As a check upon the induction examination and the physical inspection at the reception center, it was provided that "at or near the completion of a basic training, each enlisted man will be given a physical inspection by one or more medical officers and his profile verified, or revised upward or downward as the findings were."

The supplement further provided that (1) a profile would be accomplished on all enlisted men not previously profiled, who were returned to duty from hospitals; (2) a profile would be accomplished on all enlisted men not previously profiled, who were assigned to units or installations by personnel reassignment centers and redistribution stations; and (3) if it was believed that an individual's profile should be revised either upward or downward at some later date, the unit commander was charged with the responsibility of having the soldier examined by a profile classification board of three officers, consisting of a line officer, a medical officer, and a classification officer.

In mental cases, it was stipulated that a psychiatrist would replace the classification officer. If the profile classification board found that a change in the profile was warranted, such a change could be made by the board without the necessity of hospitalization. After a profile had been verified

or revised, it was not subject to review until a period of 3 months, unless the individual concerned suffered some illness or injury resulting in a marked deterioration, which would indicate that a review was necessary.

On 30 June 1945, the Physical Profile Serial was revised in another supplement to MR 1–9. Whereas, formerly numeral 1 under *S* (neuropsychiatric) designated personnel who were "emotionally stable and those with transient mild psychoneurotic manifestations incident to imminent departure for oversea assignment," in the revision, numeral 1 simply included individuals who had no psychiatric disorder. The revision also added a numeral rating of 2 under *S*, which included: "Mild transient psychoneurotic reaction. Mild psychopathic personality. Borderline mental deficiency." Numeral rating 3 under *S* was enlarged by adding "Mental deficiency, mild in degree." Numeral 4 was changed from "Below minimum standards for induction. Disqualifying except for those who had performed adequately in current assignment," to "Psychosis (or authenticated history of). Moderate or severe chronic psychoneuroses. Severe transient psychoneuroses (situation). Marked degrees of psychopathic personalities. Marked mental deficiency."

Under the heading "Factors to be considered," the revision required modifying statements relative to—

> Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external and precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorders. Impairment of functional capacity.

MEDICAL SURVEY PROGRAM

Establishment

As the war progressed and the need for manpower grew more imperative, it became more apparent to all concerned that a method of selection which depended solely upon a brief examination at the induction station that obtained only a cross sectional view of a registrant's personality was an ineffective screening procedure. To facilitate more efficient selection, a longitudinal section or history of the individual's past experiences was needed. The only national organization that was in a position to undertake the task of providing the necessary historical data was the Selective Service System. Thus, after considerable groundwork and research, the Medical Survey Program came into being. The organization and operation of this program was outlined in Medical Circular No. 4, of the Selective Service System, issued on 18 October 1943. As was stated in the introduction of that circular:

> The Selective Service System has provided this Medical Survey Program to furnish the Armed Forces induction stations with adequate medical, social, and educational histories on each registrant. The Selective Service System and the Armed Forces want

to make certain that the greatest possible care is taken, (1) to accept those registrants whose previous medical and social history indicate their ability to adjust themselves under situations of stress, including those who may be termed "borderline" cases; and (2) to reject those registrants whose condition is such as positively indicates physical or mental breakdown, or failure to adjust themselves to the responsibilities of military service after being inducted.

The circular further stated:

Information regarding a registrant's medical and social history as revealed in health, education, employment, and social records is important in properly determining whether a registrant should be accepted or rejected.

Under section 623.33(*d*), Selective Service Regulations[24] local boards were charged with the responsibility of assembling pertinent information concerning the medical and social history of registrants. In order to provide the necessary personnel to carry out the gathering of such information, an amendment was made on 4 October 1943, to part 603, of the Selective Service Regulations (section 603.85, Appointment and Duties). These regulations provided for a field agent in each local board and, further, provided: "States may request permission to continue using an established medical survey program."

Details of the Medical Survey Program, as described in Medical Circular No. 4, dealt with procedures for obtaining information on the educational background and the medical and social history of the registrants; also, the forms to be used therefor. For the educational history, the form to be used, DSS 214 (Special School Report), contained space for comments by the registrant's past teachers as to his conduct in school, his adjustment or maladjustment in the school community, and other pertinent facts regarding his school career.

Deficiencies

Of the various forms, DSS Form 212 (Medical and Social History) was the most valuable. The completion of this form depended upon the activity of the medical field agent concerned. Although many field agents, especially in the Eastern States, were well qualified and turned in a creditable job, the vast majority were not prepared to accomplish this mission effectively either from the standpoint of training or from a standpoint of their own educational background. Clearly, trained social workers were needed to perform this task, but such personnel were extremely limited in number, and most were already occupied in either governmental or private enterprise. This scarcity of trained social workers constituted the greatest single handicap to the program.

As a direct result of this deficiency, it became apparent that a ma-

[24] The procedures followed by Selective Service were detailed in Selective Service Regulations under the 1940 act. These were issued in two editions. The first was by Executive order of the President and covered the period of 23 September 1940 to 1 February 1942. The second edition, issued in three printings, was for 1 February 1942 to 31 March 1947.—A. L. A.

jority of forms received at induction stations did not contain much useful information. There seemed to be a marked tendency on the part of schoolteachers to indicate their own appraisal of the individual and to make recommendations. For instance, it was not uncommon to receive a school form with a notation, "I don't think John would make a good soldier." Because even under the best conditions it was rarely possible for a psychiatrist to see a registrant at the induction station for a time longer than 4 or 5 minutes, except for questionable cases, the examining psychiatrists came to believe that it was not worthwhile, from a time standpoint, to open the sealed envelopes and sort out the various forms, only to discover, after reading them, that the information sought for was not to be found. Not only were many blank forms received, obviously without any information whatsoever, but examiners objected to the type of data that were forwarded. In this regard, examiners repeatedly stated that factual material was wanted, not opinions of untrained persons who gather the information. This lack of capable field agents was scarcely amendable to correction as time, funds, and facilities were not available for their training.

Efforts Toward Improvement

As time went on, the Medical Survey Program did improve somewhat in quality and quantity of forms received. A stimulus in this respect was the publication of TB MED 33 (p. 169) which directed attention of all psychiatric induction examiners to the Medical Survey Program. The bulletin pointed out that one or more trained psychiatric social workers could be of much assistance to the neuropsychiatric examiner in obtaining and organizing such historical data. However, because of the various factors already outlined, there continued to be much frustration and difficulty connected with the utilization of the medical survey forms at the induction stations.

On 22 September 1944, a conference was held at the National Headquarters, Selective Service System, on the subject of the Medical Survey Program. Officers and representatives from the Selective Service System, the Office of The Surgeon General (Army), the Bureau of Medicine and Surgery (Navy), the National Committee for Mental Hygiene, the Social Security Administration, and the American Association of Psychiatric Social Workers met and discussed the program.

The representative from the Surgeon General's Office reported on the results of a survey which had been initiated at the request of The Surgeon General. On 11 March 1944, a letter had been forwarded from the Surgeon General's Office to all service commands, requesting information relative to the effectiveness of the individual medical and social histories as obtained through the Medical Survey Program. Most of the replies received were markedly critical of the value of the reports. (See

also pp. 181–183). It was pointed out that the crux of the problem lay in the lack of trained medical field agents. Also, that the examining psychiatrists were almost unanimous in stating that they desired positive statements in the histories. The outstanding need from their standpoint was for answers to such questions as: "Did or did not the registrant ever have epilepsy, enuresis, somnambulism, history of arrest, previous nervous breakdown or other definite disease entity?" It was also pointed out that the forms as they were constructed stressed only pathology. It was suggested that it would be desirable, in cases of individuals who were adjusted and valuable citizens in the community, to make some positive statement to that effect on the DSS Form 212.

Inasmuch as one of the chief criticisms aimed at the program by induction station psychiatrists was that they did not have sufficient time to thumb through the many forms, a suggestion was made that the solution to this problem would be to install a trained psychiatric social worker in each induction station to review the form and summarize the information on a face sheet, which would then be forwarded to the psychiatrist in the examining line. This idea was unanimously approved, and it was agreed that steps would be taken to put this plan into action. A representative of the Director of the Budget stated that the money could be provided. Representatives of the Federal Security Agency and the American Association of Psychiatric Social Workers stated that perhaps private agencies could spare, on a part-time basis, some trained workers for this important job.

On 23 September, a committee, consisting of Dr. Winfred Overholser, Dr. Raymond W. Waggoner, Col. Louis H. Renfrow, and a representative from the Surgeon General's Office, met to take up the question of revision of forms. Certain recommendations as to alterations, deletions, and additions to the forms were made.

The Surgeon General's Office remained firmly convinced of the value of such a longitudinal history and believed that even with its deficiencies the Medical Survey Program was superior to no program at all. Consequently, on 14 March 1945, a letter on the utilization of medical survey forms, sent to each service command and oversea department, stressed the value and objectives of the Medical Survey Program. Cooperation was directed, and it was provided that, if available, a competent male psychiatric social worker would be stationed in each induction station for the purpose of opening, evaluating, and passing on to the proper examiner at the proper time the various forms dealing with the registrants.

Further Modifications

In order to further facilitate the program, the Army and the Selective Service System jointly agreed that, at the end of each day of induction processing, the forms would be stamped either "pertinent" or "not perti-

nent." The forms would then be forwarded to the State headquarters of the Selective Service System, from which State the registrant had originated. The Selective Service System, on its part, agreed to have a trained social worker on duty in each of its State headquarters, whose duty it would be to select the forms stamped "not pertinent," determine which medical field agent had prepared the form, and then, in order to improve the quality of work in the future, visit and help instruct that agent in his or her duties.

This practice of stamping "pertinent" or "not pertinent" was continued until the spring of 1946, after the war had ended. On 25 March 1946, a letter to each service command and oversea department, also on the utilization of medical survey forms, ordered the discontinuance of the stamping of "not pertinent" and "pertinent," as the case might be, and the substitution therefore of stamping "acceptable" or "rejectable."

Evaluation

In an attempt to evaluate the helpfulness and efficiency of the Medical Survey Program, the Surgeon General's Office, in the spring of 1945, requested the various service commands to render a report on the program. Replies varied considerably in the estimate of the degree of helpfulness of the program. For instance, the First Service Command reported that forms were submitted on only 50 percent of registrants and that, of the forms submitted, only 20 percent contained positive information. However, they evaluated it as follows: "Reports considered definite aids in formulating decisions in all stations."

The Second Service Command, exclusive of New York City, reported that forms were submitted on 50 percent of the registrants. However, they stated: "Social and medical information generally valuable, but frequently received after examination."

The induction stations in the Fourth Service Command gave varying reports on the number of forms submitted and indicated that positive information was contained in the forms in 1 to 75 percent. They stated that sometimes 100 percent were negative or blank and of no value. Camp Shelby Induction Station, Miss., reported that 10 percent were valuable. Fort Jackson Induction Station, S.C., reported "value of survey forms extremely small." Fort Bragg Induction Station, N.C., reported "valuable information rarely obtained." Fort McClellan Induction Station, Ala., reported "very small." For example, of 225 forms submitted, only 70 contained positive information, and of these, only 6 contained valuable information. Fort Benning Induction Station, Ga., reported "helpful on rare occasions." Fort Oglethorpe Induction Station, Ga., reported "occasionally helpful in rejecting men." Camp Blanding Induction Station, Fla., reported "bulk of forms are valueless."

In the Fifth Service Command, it was reported that from 20 to 25

percent of all registrants had forms submitted and that of these 5⅛ percent contained positive information. However, they also reported that from 95 down to 92 percent were negative or blank. The opinion in the Fifth Service Command varied. For instance, the Cleveland, Ohio, Induction Station's general impression was "if forms were utilized to their fullest extent they would be of considerable help to the psychiatrist." The Fort Hayes Induction Station, Columbus, Ohio, stated: "The general utilization of all examiners indicates forms are not worthwhile." The Huntington, Ind., Induction Station reported "only a few forms have significant information."

In the Seventh Service Command, only 15 percent of the registrants had forms submitted. The Minnesota-St. Paul area, however, received forms on 50 percent of the registrants. The Seventh Service Command surgeon estimated that 15 percent of the forms contained positive information.

In the Ninth Service Command, the figures and opinions reported varied widely. For instance, Seattle, Wash., claimed that forms were received on only 2 percent of registrants, while Portland, Ore., reported that forms were received on 22 percent of the registrants. However, the percent of positive information contained was a varying figure, the lowest being 2 percent, the highest 8 percent. The estimate at Portland was "actual use is disappointing." The San Francisco, Calif., Induction Station reported that they received forms on 14.4 percent of their registrants, but that only four-tenths of the forms contained positive information. It was estimated, by the San Francisco station, that the forms were of practically no value. Phoenix, Ariz., Induction Station received forms on 14 percent of their registrants, but only 5 percent of the forms contained positive information and 95 percent were received blank or negative. The Phoenix station stated that the information was of no value. Butte, Mont., however, stated that they received forms on 60 percent of their registrants and that 75 percent of the forms received contained positive information and that only 25 percent were received blank or negative. They claimed, however, that only 2 to 3 percent of the forms contained information of value. The State as a whole claimed that only less than 1 percent contained information of value. The Los Angeles, Calif., Induction Station received forms on 28 percent of the men, 20 percent of which contained positive information and 80 percent of which were negative or blank. However, their estimate was "no value at present." The Sacramento, Calif., Induction Station stated that information of value was obtained on less than 1 percent of the registrants. The Fort Douglas, Utah, Induction Station, receiving registrants from Utah, Montana, and Idaho, stated that only 1 percent of the forms contained information of value. Thus, as judged by the men who were actually making use of the forms of the Medical Survey Program, this program was disappointing

in its operation. As has been previously outlined, the reasons for this were all too apparent.

Reduction in Scope of Program

By the summer of 1946, it was possible to reduce the scope of the Medical Survey Program. This could now be accomplished, as stated in a local board memorandum [25] on the subject of medical survey, because of the reduction of calls by the Armed Forces and of the recruitment of a number of men through voluntary enlistments.

This memorandum stressed, however, that it was still incumbent upon local boards, with the assistance of the local board examining physician and such agencies as were designated by the State Director, to obtain from all possible sources information relating to a registrant's qualification; further, that the fundamental principle of exercising care in the selection of men free from mental conditions of a disqualifying nature remained the same. It pointed out that the desired information might be secured from other local social agencies, school systems, hospitals, training schools for the handicapped, or any other available service. It was decided to continue the use of DSS Form 210 and DSS Form 212, the identity verification and medical and social history forms, respectively. However, the educational verification, the cooperative school report, and the special school report (DSS Forms 211, 213, and 214, respectively) were all discontinued.

It was again provided that States having their own established programs of obtaining such information might request and receive permission to continue their own programs. The amended memorandum described the procedure for securing medical and social histories, substantially, as follows:

When the local board knew or had reason to believe that there existed a history of mental disease in the family of a registrant, or that the registrant was socially maladjusted, had a poor work record, or possessed other mental or personality disorders, or any physical condition which might cause the Armed Forces ultimately to reject him, it would prepare DSS Form 212 (part 1) and add a statement giving the reason for requesting the investigation. After completing part 1, the local board was to transmit the form to the medical field agent.

The medical field agent, upon receipt of Form 212, with part 1 completed, was to obtain the information necessary for completing part 2. When this part was completed, the medical field agent was to return the form, in a sealed envelope, to the local board, addressed to the medical examiner of the Armed Forces induction station, with the name, address, and order number of the registrant on the envelope. This envelope and

[25] Local Board Memorandum No. 186, Selective Service System, issued on 2 Oct. 1943; amended on 8 Aug. 1946.

its contents were to be available to no one except the medical examiner at the Armed Forces induction station, or subsequently to the Selective Service medical advisory board, if the registrant was deemed by the local board to have been erroneously rejected for, or discharged from, the Armed Forces.

When the registrant for whom the forms had been obtained was forwarded for induction, the local board was to forward such forms, in the sealed envelopes to the induction station to which registrant was sent. At the end of the day at the induction station, the forms were stamped as accepted or rejected as the case might be, and forwarded to the State Director of the Selective Service System, in the State from which the registrant had originated.

Summary

The Medical Survey Program was designed to meet a very real need in the proper selection of men suitable for service. The shortcomings of this program were:

1. The shortage of trained psychiatric or other social workers in the positions of medical field agents, with the consequent result that the histories were, for the most part, inferior and lacking in the required factual information.

2. The lack of trained personnel, including social workers, in the induction station and in the military forces to provide for the opening, evaluating, and proper handling of the material obtained through the program. In order to have made the program function properly, obviously, there should have been an arrangement which, as has been shown was presumably provided for by directive, whereby only factual material of value would have been presented to the examining psychiatrist at the time he examined the registrant in question. When time is at a premium, as it is in a busy induction station, it is not practicable for the examining psychiatrist to open and evaluate the material himself.

3. There was a deficiency in the overall supervision of this program, both on the part of the Selective Service System and on the part of the Armed Forces. In the first place, the Selective Service System should have provided experienced and adequately trained personnel, to its State headquarters, to supervise and help medical field agents in properly carrying out their part of the program. In the second place, the Armed Forces should have provided more adequate supervision in the induction station, as has been outlined.

4. It would seem that, to obtain the most out of such a program, it would be advisable to make available to the medical advisory board psychiatrist the information gathered by the Medical Survey Program and to allow the psychiatrist to make a personal examination of the registrant before actual induction. If indicated, the psychiatrist could

request further information. When the examination was completed, the psychiatrist could submit a summary of his findings and recommendations regarding the desirability of inducting such a registrant.

5. Despite this program's shortcomings and its disappointing showing, psychiatrists are united in their belief that such a program, effectively carried out, would be of the greatest value in the selection of men for the Armed Forces.

NEUROPSYCHIATRIC SCREENING ADJUNCT

During the mobilization period, and certainly with the onset of war, it became apparent that there were an insufficient number of psychiatrists to conduct a reasonably thorough routine psychiatric evaluation of each inductee. Initially, 15 minutes was sought as a minimum time for the psychiatric induction examination. However, with the heavy workload for each induction station, it soon became evident that even 5 minutes was an overly optimistic expectation for the psychiatric examination and that, in actual practice, 2 minutes or less was the most time that could be allotted. Even then, the number of psychiatrists was insufficient, and many nonpsychiatric physicians were pressed into service as induction psychiatric examiners. It seemed evident that a solution for this problem could be a screening device of a paper-and-pencil type, to be group administered, and thus economize upon the utilization of psychiatrists by reducing the number of inductees who required an individual examination. To be effective, such a screening test would permit the majority of inductees who were free of overt or latent mental disorders to enter the service without an individual psychiatric examination, but would identify a large minority, perhaps one-third of inductees, in whom were contained the potential psychiatric problems. Thus, the screening test would not replace the psychiatric examination but would select the group most likely to have sufficient psychopathology as to constitute a hazard or risk for military service.

Screen paper and pencil tests of a "homemade" type, empirically constructed, were already being used by some of the induction station psychiatrists. These tests consisted of a series of questions which could be readily answered by the inductee, sometimes aided by an enlisted assistant, and which referred to the existence, past and present, of psychosomatic manifestations, psychiatric symptoms, antisocial behavior, and the like. Such tests saved the time of the examiner, particularly for those individuals who would admit having positive symptomatology.

An effort to construct a valid screening adjunct was initiated by Maj. John W. Appel, MC, Chief of Preventive Psychiatry, Neuropsychiatry Consultants Division of the Surgeon General's Office. He requested the Research Branch of the Information and Education Division, Army Service Forces, to construct the test. Since most of the psychiatric problems of

World War II were demonstrated to be of the psychoneurotic type, efforts were made initially to identify mainly this group. Research was conducted for the purpose of comparing the responses of a cross section of Army personnel with that of a sample of psychoneurotic patients in Army hospitals. Eventually, a questionnaire was evolved which, in addition to background information, inquired into 15 major areas of the individual's past and present experience and current attitudes as follows:

1. Childhood relations with parents.
2. Childhood fears.
3. Childhood neurotic symptoms.
4. Childhood school adjustment.
5. Childhood fighting behavior.
6. Childhood participation in sports.
7. Emancipation from parents.
8. Mobility.
9. Sociality.
10. Identification with the war effort.
11. Acceptance of soldier's role.
12. Worrying.
13. Oversensitivity.
14. Personal adjustment.
15. Psychosomatic complaints.

The questionnaire was necessarily incomplete for induction screening since it was only based upon the identification of psychoneurotics. Further questions were needed to detect psychotics and psychopaths. For this reason, there were added 8 specific questions which were not consolidated with the many questions under the 15 original items. These separate questions were treated qualitatively, and even a single affirmative answer was to be considered a critical sign and sufficient reason for referral for individual psychiatric evaluation. Thus, the final test result consisted of two parts: a numerical score obtained from the psychoneurotic test battery and a series of yes-or-no answers for the eight separate questions. Men with scores considered critical in either respect, that is, low numerical scores under the psychoneurotic scale or the possession of one or more affirmative answers to the separate questions, were to be considered screened by the test and referred to individual psychiatric evaluation. Those with passing numerical scores for psychoneuroses and negative critical signs for the other questions were to be passed by the test as not requiring individual psychiatric examination.[26]

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[26] The exact questions, to be answered by a simple "yes" or "no," were:
1. Have you ever had stomach ulcers?
2. Do you ever take dope?
3. Have you ever had fits or convulsions since you were ten years old?
4. Did you ever have a nervous breakdown?
5. Were you ever a patient in a mental hospital (because of your nerves)?
6. Were you ever sent to reform school?

Official adoption.—The NSA (Neuropsychiatric Screening Adjunct) was ordered officially adopted for use at all induction stations beginning on 1 October 1944, by WD (War Department) Memorandum No. 40–44, issued on 19 September 1944. By this time, however, the extreme need for the NSA to relieve pressure on the psychiatrists had diminished, and it was never considered necessary to make full use of the test in passing certain men without individual examination. For example, according to WD Memorandum No. 40–44, "men who score 18 or above on the NSA and who have no critical signs, regardless of score may, at the discretion of the psychiatrist, be considered neuropsychiatrically acceptable for induction without further examination." Further in the memorandum, however, it was stated: "Nothing herein will be interpreted as restricting the responsibility of the neuropsychiatrist for examining registrants in accordance with the provisions of MR 1–9, 19 April 1944 * * *."

Results.—As stated by the authors of NSA: "It would not be surprising if by a good many clinicians it was either treated with tolerant amusement or completely ignored, even though their own clinical examination hardly could be more than perfunctory in the majority of cases." [27] The test scores, however, were available to the examining physicians who were free to use them or discard them.

It should be recognized that the NSA was not designed to predict success or failure in the Army but rather to predict the professional opinion of the examining psychiatrist as to rejection or acceptance for military service on the basis of the absence or presence of mental disorder. For this reason, a basic difficulty in the standardization of the NSA was the extremely wide variation in the frequency of psychiatric rejections, ranging from 0.5 percent at Camp Beale, Calif., to 50.6 percent at Manchester, N. H. Also, there were marked differences in specific diagnoses. For example, there were 29 stations in which the dominant tendency was to classify men as psychoneurotic, 16 in which psychiatric rejectees were most often diagnosed as psychopaths, and 10 in which neither of these labels was used. It is difficult to believe that Pittsburgh, Pa., had three times the proportion of psychiatric rejects as Philadelphia, Pa.; Detroit, Mich., three times the number of Chicago, Ill.; New Orleans, La., three times that of Dallas, Tex.; and Seattle, Wash.-Portland, Oreg., three times that of San Francisco, Calif. Further, that New Haven, Conn., had 3 times as many psychopaths as Boston, Mass.; Pittsburgh, 5 times as many as Baltimore, Md.; and Camp Shelby, Miss., 35 times as many as Fort McClellan, Ala.[28]

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7. Have you ever gotten into serious trouble or lost your job because of drinking?
8. Do you ever wet the bed? (This means urinate in bed, *not* wet dreams.)

[27] Stouffer, Samuel A.; Guttman, Louis; Suchman, Edward; Lazarsfeld, Paul F.; Star, Shirley A.; and Clausen, John A.: Studies in Social Psychology in World War II. Volume IV. Measurement and Prediction. Princeton: Princeton University Press, 1950, p. 549.

[28] *Ibid.*, pp. 550–555.

Despite the aforementioned considerable variations in both the number and the cause for psychiatric rejections at the different induction stations, the NSA was successful in selecting four out of five men, approximately 80 percent, subsequently diagnosed as psychoneurotic at a cost of screening, as unfit, approximately 20 percent of men subsequently passed as fit for military service. However, the test was not so successful in people diagnosed psychopathic, screening approximately 70 percent. Even less successful were other diagnostic categories for which there were wider variations from one station to another.

The authors of the test concluded that NSA could have served as a useful signal to point out the man who needed a thorough examination and to point out another who needed only cursory inspection. If practiced earlier in the war, the savings in efficiency and manpower might have been enormous. On the other hand, they commented: "Until, however, psychiatric diagnosis is better standardized than it is today, it is likely that the predictability of psychiatric screening tests will fall far short of ideal." [29]

In another study,[30] comparing the efficiency of the Cornell Selectee Index, Form N, and the NSA with the findings of two psychiatrists doing their customary screening examinations and not seeing the screening forms, the results were as follows:

Form N of the Cornell Selectee Index and the NSA both screened approximately 80 percent of the individuals found by the psychiatrists to be militarily unfit. In essence, these screening devices were approximately 80 percent as effective as the individual psychiatric examination. However, the NSA was considered to be superior to the Cornell Selectee Index form, for its phraseology was simpler and the results were more easily perused by the examiner.

EFFECTIVENESS OF THE NEUROPSYCHIATRIC SCREENING

Early in 1944, an attempt was made by the Surgeon General's Office [31] to evaluate the effectiveness of neuropsychiatric screening in identifying potential neuropsychiatric casualties.[32] Toward this end, 10 induction stations were selected which had been rated beforehand as "good," "fair," and "poor," with respect to the quality of their neuropsychiatric prescreening examination.[33] Data were then obtained on disqualifications for neuropsychiatric reasons of men examined for military service at these stations

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[29] Stouffer, *et al., op. cit.*, p. 567.

[30] Leavitt, H. C., and Graham, H.: A Comparison Between the Neuropsychiatric Screening Adjunct (NSA) and the Cornell Selectee Index (Form N). Am. J. Psychiat. 103: 353–357, July 1946–May 1947.

[31] The information in this section is based on material furnished by Dr. Bernard D. Karpinos, Special Assistant for Manpower Studies, Medical Statistics Agency, Office of The Surgeon General, Department of the Army, 4 Mar. 1964.—A. L. A.

[32] The neuropsychiatric screening was aided at that time by the NSA (p. 185) and special background material (Medical Survey Program, p. 177) obtained before the psychiatric examination.—A. L. A.

[33] The rating was done by Lt. Col. Malcolm J. Farrell, MC, Neuropsychiatry Division, SGO.—A. L. A.

and on disability discharges for neuropsychiatric conditions of persons inducted from these stations. The apparent objective was to relate these types of data—the assumption obviously being that the induction stations rated qualitatively higher and showing higher disqualification rates should show lower discharge rates, and vice versa. In other words, a negative association was presumed between the disqualification and the discharge data. The obtained data are presented in table 1.

TABLE 1.—*Disqualification and discharge rates for neuropsychiatric reasons, at selected induction stations, 1943*

Rating[1] and induction station	Rate		Rating[1] and induction station	Rate	
	Disqualification, per 1,000 examined[2]	Discharge for disability, per 1,000 inducted[3]		Disqualification, per 1,000 examined[2]	Discharge for disability, per 1,000 inducted[3]
Good:			Fair—Continued		
Detroit, Mich.	108	15	Camp Croft, S.C.	59	16
New York, N.Y.	107	18			
Boston, Mass.	133	11	Total	62	17
Total	112	16	Poor:		
			Shreveport, La.	79	15
Fair:			Tyler, Tex.	109	21
Fort Benning, Ga.	59	16	Lubbock, Tex.	11	18
Fort McClellan, Ala.	70	18	Santa Fe, N. Mex.	144	16
			Total	92	18

[1] "Rating" relates to the quality of the neuropsychiatric examination, as evaluated beforehand by the Neuropsychiatry Division, SGO.

[2] Based on neuropsychiatric disqualification data of men examined at these induction stations during the 7-month period from June 1943 through December 1943.

[3] Based on data for men from these stations discharged for disability. The rates were computed by relating these discharges that occurred during the 6-month period from May 1943 through October 1943 to the number of individuals inducted from these stations during the 6-month period from January 1943 through June 1943.

Source: Memorandum, Director of the Medical Statistics Division, SGO, for Director of the Neuropsychiatry Division, SGO (dated apparently early in 1944), subject: Neuropsychiatric Discharge Rates.

The data on disqualification for neuropsychiatric reasons deal with men who were examined for military service at these selected stations during the 7-month period, from June 1943 through December 1943. The data were taken from the monthly reports (SG Form 366) submitted by the induction stations to the Surgeon General's Office. These disqualifications may reflect the effect of two directives of that period. The first was The Adjutant General's letter, in May, which abolished the quota for illiterates and made all men who could meet the minimum intelligence standards acceptable for induction into the Army. The second was a directive from the Surgeon General's Office which instructed that all men who failed to meet the minimum intelligence standards be classified under mental

deficiency (counted, obviously, as psychiatric rejections) on the monthly reports, starting with the October (1943) report. It is impossible to determine to what extent these two directives variably affected the reports of the selected stations. But, whatever these effects, the data clearly indicate wide variation among these stations in the disqualification rates for neuropsychiatric reasons (table 1, col. 1). With the exception of Tyler (Tex.) and Sante Fe (N. Mex.) which were rated "poor," higher disqualification rates for neuropsychiatric reasons were associated with the stations rated "good."

The data on disability discharges (table 1, col. 2) deal with individuals from these stations discharged for neuropsychiatric reasons during the 6-month period, from May 1943 through October 1943. The data were based on medical discharge reports received by The Adjutant General. The discharge rates were computed by relating these discharges to individuals inducted from these stations during the 6-month period, from January 1943 through June 1943. These figures are obviously incomplete, since some of the men inducted in the first 3 months of 1943 were, undoubtedly, discharged previous to May, and some of the men who were inducted during the first 6 months of 1943 could have been discharged after October 1943.

Irrespective of the variation in their rating and in their disqualification rates, these stations indicated only slight differences in their discharge rates—clearly not commensurable with the variations in their disqualification rates. It must be recognized, however, in evaluating these data, that these stations do not represent homogeneous populations. Whereas the "poor" and "fair" stations obviously drew their examinees primarily from rural and semirural areas, the examinees of the "good" stations came chiefly from urban areas. These differences also involve, of course, regional as well as ethnic factors. The initial prevalence of the neuropsychiatric conditions could have been different at the various stations.

The evaluation is further complicated by the fact that the study was limited to disability discharges which dealt presumably with more serious and, consequently, more easily recognizable neuropsychiatric conditions, but it left out all those men who were administratively discharged for unsuitability or unfitness (sec. VIII, AR 615–360) or for the convenience of the Government (sec. X, AR 615–360). These pertinent data were apparently not available by station.

If these data were only suggestive, without providing conclusive evaluative evidence as to the effectiveness of the neuropsychiatric screening in World War II,[34] a series of followup studies [35] published after the war

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[34] A comparative analysis of these data showed a very low negative association between these data; namely, a rank correlation of —.15 (Karpinos).

[35] (1) Egan, J. R., Jackson, L., and Eanes, R. H.: A Study of Neuropsychiatric Rejectees. J.A.M.A. 145: 466–469, 17 Feb. 1951. (2) Brill, N. Q., and Beebe, G. W.: Psychoneuroses; Military Applications of a Follow-Up Study. U.S. Armed Forces M.J. 3: 15–33, January 1952. (3) Brill, N. Q., and Beebe, G. W.: Some Applications of Follow-Up Study to Psychiatric Standards for Mobilization. Am. J. Psychiat. 109: 401–410, December 1952. (4) Glass, A. J., and others: Psychiatric Prediction and Military Effectiveness. U.S. Armed Forces M.J. 7: 1427–1443, October 1956; 7: 1575–1588, November 1956; 8: 346–357, March 1957.

clearly demonstrated its various difficulties and shortcomings. These studies led to a general recognition that the psychiatric standards and procedures of World War II were obviously overcautious and, hence, caused a considerable and unnecessary loss of potential military manpower. They also indicated that psychiatric and psychological criteria at the time of examination for military service generally have not proved a reliable index for efficiently predicting future behavior and, furthermore, that greater proficiency can be accomplished by observing individuals with psychiatric difficulties under military conditions, rather than by psychiatric screening, at the time of their examination. As a result, both the psychiatric standards and the psychiatric processing procedures of World War II were modified.

In line with this new orientation, psychoneurosis of any degree is now considered acceptable if it had not incapacitated the person in civilian life, or if the person has otherwise clearly demonstrated stability. The current psychiatric evaluation at the Armed Forces examining station is done by the examining physician as a part of the general medical examination. (The NSA and other routine supplementary psychiatric aids have been eliminated.) The examining physician or the medical officer of the station determines the necessity for a psychiatric evaluation by a qualified psychiatrist. Some of the larger stations employ full-time psychiatrists for this purpose. Most of the stations, however, avail themselves of a psychiatrist's service on a consultation basis. Basically, the current psychiatric screening is intended to eliminate only gross psychiatric conditions.[36]

[36] As a result of this liberalized policy, the current disqualification rate for psychiatric reasons is 1.9 percent per 1,000 examinees, as compared with the 5.5 percent of psychiatric disqualifications in World War II. *See* (1) Karpinos, B. D.: Qualification of American Youths for Military Service, Medical Statistics Division, Office of The Surgeon General, Department of the Army, 1962; (2) appendix A, table 10; and (3) Voth, H. M.: Psychiatric Screening in the Armed Forces. Am. J. Psychiat. 110: 748–753, April 1954.—A. L. A.

Part III

MILITARY PSYCHIATRY IN PRACTICE

CHAPTER IX

Hospitalization and Disposition

Norman Q. Brill, M.D.

From the standpoint of hospitalization in the United States, World War II can be divided into two periods: One, the period of mobilization which extended from September 1940 to the latter part of 1942; the other, the period of combat, from the latter part of 1942 until the end of the war. During the first period, the major medical activities were centered, mainly, in the station hospitals. In the second period, emphasis shifted to general and convalescent hospitals.

INITIAL PROBLEMS

During the mobilization period, the Army was expanding rapidly, new organizations were being activated, training was hurried, and outfits were being prepared for oversea shipment. The Allied military situation looked dark and the future uncertain.

From the beginning, large numbers of men were admitted to the various station hospitals because of psychiatric disorders. Many were frankly psychotic or psychoneurotic; others were immature, mentally defective, or had personality or character disorders which interfered with their adjustment. The hope that had been nourished by some, that induction screening would leave the Army free of neuropsychiatric problems, soon waned.

Generally, if a soldier consistently did not adjust at duty, he was referred to the hospital. Dispensary medical officers did little in the way of therapy. They were kept busy screening the many men who reported daily on sick call, trying to get as many as possible back to their duties promptly. Outpatient specialty clinics had not yet been organized.

While the types of psychiatric syndromes seen in the Army were, for the most part, the same as those seen in civilian life,[1] the fact that specific dispositions had to be made with patients in the Army led to certain difficulties and complications which were not experienced in civilian practice. In the service, an arbitrary distinction was made between the type of discharge for those who were considered ill by virtue of mental disease and for those who had personality or intellectual disorders. Psychoses and psychoneurotic disorders were included in the category of illness while the

[1] Many psychiatrists would take issue with this statement on the grounds that rarely would such immature, personality, or neurotic disorders be self-referred or sent to civilian psychiatrists. No doubt, such cases in lesser numbers were seen by general practitioners.—A. J. G.

various types of psychopathic personality, mental deficiency, enuresis, and the like were not.[2] Personnel who were incapacitated for service by "illness" were given medical discharges while those who "were inapt" or "did not possess the required degree of adaptability or who had habits or traits of character which served to render retention in the service undesirable" were to be given administrative (nonmedical) discharges upon the recommendation of a board of line officers appointed to consider their cases.[3] The Medical Department, therefore, had no direct control over the retention or discharge of this latter group. Its function was merely to make recommendations.

The criteria for medical discharge were laid down by War Department directives. At one time, it was directed that all men with psychoneurotic disorders be discharged medically while, at another time, it was directed that if a man were capable of performing any duty he was to be retained in the service regardless of diagnosis.[4]

It was extremely difficult, in many instances, for medical officers to decide about the type of discharge that should be recommended. Many times, individuals who were mentally defective or emotionally immature would develop anxiety or conversion reactions as a result of the minimal stress of entering military service. Their acute symptoms would subside when placed in the protective environment of the hospital, but recurrence could be expected if they were returned to duty. Many such individuals could be salvaged with job assignments which were appropriate to their capabilities but, unfortunately, such assignments were not always available.

Similarly, many individuals were seen with neurotic symptoms or histories of maladjustment which could be related quite definitely to some specific situation in the military service. There were conflicting opinions about whether such cases should be called psychoneurotic disorders or instances of lack of adaptability.

From the beginning of mobilization, psychiatrists were impressed with the poor motivation of many patients who found their way into hospitals. It was difficult to define exactly how much of such patients' ineffectiveness was due to illness and how much to lack of desire to do their part. Seemingly conscious exaggeration of existing defects was not uncommon.

As the war progressed, an increasing number of men who had been returned to the Zone of Interior after having served overseas showed overt evidence of maladjustment. They complained; were not as cooperative as

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[2] It is pertinent to note that such a distinction was not made in World War I. Mental deficiency, chronic alcoholism, constitutional psychopathic states, or personality disorders, and even drug addiction, were usually given discharges for disability if persons having such defects were considered unfit for service. See appendix A, table 8.—A. J. G.

[3] As provided by section VIII, AR 615–360, the company or unit commander was responsible for initiating such administrative discharges, including the gathering of necessary evidence to support the action for discharge. Line (nonmedical) officers generally constituted the board which considered the case, and the next higher commander (the convening authority) was responsible for processing the action. A reviewing authority, usually a general officer, implemented the actual discharge.—A. J. G.

[4] Appel, J. W.: Incidence of Neuropsychiatric Disorders in the United States Army in World War II (Preliminary Report). Am. J. Psychiat. 102: 433–436, January 1946.

they had been previously; and were irritable, somewhat tense and restless, subject to emotional outbursts and admittedly unwilling to continue to serve. They frankly proclaimed that they had done their share and felt under no compulsion or obligation to continue contributing their efforts. Medical officers who struggled with this problem for a long time received little help or guidance from the War Department—until it was too late in the war effort. There was considerable difference of opinion concerning the significance of these altered attitudes. Some psychiatrists insisted that they represented psychoneurotic disorders which justified disability discharges. Others, admitting that these attitudes were evidences of maladjustment, were nevertheless reluctant to categorize them as psychoneuroses. The problem was an important one for, if the former view were adopted, it would imply that defective motivation in general was an evidence of illness and that its manifestations were to be treated medically and not administratively.

Psychoneurosis was difficult to define, and apparently, it could not be clearly differentiated from other psychiatric diagnoses of transient reactions or personality disorders which were in use, such as simple adult maladjustment, emotional instability, and inadequate personality. It was not uncommon to see the same case given three different diagnoses by three different psychiatrists. The same patient might have been recommended by one psychiatrist for disability discharge and for return to duty by another.

LIBERAL DISCHARGE POLICY

The War Department policy concerning discharge of soldiers with neuropsychiatric disorders varied from time to time, the variation for the most part being based on manpower needs. In the early days of mobilization, registrants who qualified for limited service were not inducted. Consequently, there was no such classification, or duty assignment, in the Army. After evaluation in a hospital, patients were either discharged from the Army for disability or returned to full military duty. Often, patients who were not fit for strenuous field duty were returned to their outfits (not infrequently with a medical report which could not be used by their commanding officers as a basis for reassignment) where the medical officer had hoped that they could be utilized in some assignment. Occasionally, medical officers in hospitals upon their own initiative sent a note to commanding officers pointing out some physical limitation of the patient being returned to duty, but such a practice was by no means standard or required. Over a period of time, a considerable number of below-par men accumulated in all types of units.

Shortly after the beginning of hostilities, efforts were made to rid the field forces of those men who were not physically qualified for general service. The War Department directed all branches of the Army to transfer

such personnel to garrison-type duties, such as post and station complements, military police, and cadres of the replacement training centers. Many commanders of field units seized this opportunity to rid themselves of all undesirable personnel, not confining their transfers to those who were physically unfit. Steps had to be taken to stop this abuse. For example, in the Fourth Corps Area (later Service Command),[5] a letter was sent to the commanding officers of all posts drawing attention to the abuse of transferring personnel, other than those physically disqualified for field service, to the control of station commanders. Specific reference was made to deserters, men AWOL (absent without leave), absent sick in hospitals, malingerers, men who should be discharged on CDD (certificate of disability for discharge), and similar cases. This problem of disposing of noneffective personnel was one which was to plague the Army during the entire duration of the war.

A considerable percentage of the men who were transferred from field force units to garrison installations were transferred as a result of neuropsychiatric disorders, chiefly psychoneurosis. They were transferred in such large numbers that it soon became impossible for the overhead installations to absorb them, and commanders were directed[6] to discharge all men "with epilepsy, psychosis, and definite psychoneurosis." Borderline psychoneurotic cases and cases of mental deficiency who were considered useful for some limited assignment could be retained. It was also directed that "cases of constitutional psychopathic states uncomplicated by psychoses and cases of mental deficiency, with mental ages lower than 8 years, be disposed of administratively (in contrast to medically) under the provisions of Section VIII, AR 615–360."

Problems of the Psychiatrists

While many psychiatrists concurred with the spirit of Circular Letter No. 77, in the belief that the Army was no place for individuals with any clearly defined neuropsychiatric disorder, others were not of the opinion that all psychoneurotics were a total loss to the Army. The diagnosis of "borderline psychoneurosis" was not an acceptable entity to either medical officers or psychiatrists. A man either had psychoneurosis or didn't have it. Consequently, some psychiatrists, when confronted with a soldier who had a mild psychoneurotic disorder and who was thought capable of doing duty, did not record a diagnosis of psychoneurosis. If the diagnosis of psychoneurosis were made, such a patient had to be recommended for a medical discharge, which some psychiatrists did not believe to be indicated or warranted. Often, in order to return such patients to duty, the use of other diagnoses was resorted to, such as gastric neurosis, functional back-

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[5] Letter, Headquarters, Fourth Corps Area, to Commanding Officers, Posts and Stations, 28 Feb. 1942, subject: Disability Discharges.

[6] Circular Letter No. 77, Office of The Surgeon General, U. S. Army, 29 July 1942.

ache, and cephalalgia for cases of stomach and back disorders and headache which were obviously psychogenic.

Those who agreed with the policy of discharging all individuals with psychoneurotic disorders used the diagnosis freely and recommended for disability discharge practically everyone who manifested any degree of nervousness or maldajustment regardless of its cause.

Problems of Administrative Discharge

It was one thing for higher headquarters to direct the administrative discharge of individuals with psychopathic personalities or severe mental deficiency and another to get it accomplished. Many company commanders with little military experience were unfamiliar with the complex administrative procedure involved. Others, familiar with the administrative procedure, were reluctant to initiate an administrative discharge because of the considerable time that was involved and because of the unpleasantness of testifying before an individual that he had undesirable habits or traits of character or was inapt or unadaptable. In some regiments or divisions, it was felt that a good officer should be able to make a soldier out of anyone and that each "Section Eight Board" represented a failure on the part of the company commander. However, there was no such adverse reflection on the officer's ability when he arranged either for a transfer of a problem soldier to another outfit or, if possible, for a medical discharge. In those cases where there was a history of frequent hospitalization or sick call visits, the officers involved, including the reviewing authorities, often held to the opinion that such persons were sick, contrary to medical testimony, and urged disposition through medical channels.[7] In some posts, the impression existed that only malicious troublemakers and behavioral problem soldiers should be discharged under "Section 8" and that other character or personality disorders did not fall in the administrative discharge category. The overall effect of this attitude was to liberalize and stimulate medical discharges.

Maj. (later Lt. Col.) Malcolm J. Farrell, MC, in a memorandum of 11 August 1942, to The Surgeon General, on the findings of an inspection of the Station Hospital at Indiantown Gap, Pa., on 6 August 1942, commented as follows:

> Considerable difficulty is met with in the disposal of Section VIII cases (all administrative discharges). The main difficulty appeared to be in convincing line officers of the need for the separation from the service of psychopathic, mentally defective individuals, and chronic alcoholics. Repeatedly, cases studied at the hospital have been sent before Section VIII Boards where their discharge would be disapproved, mainly because the line officers of the Board could not understand the reasons for the psychiatrist's recommendations. * * * Many posts apparently felt that Section VIII (discharges) had been discontinued altogether. * * * Many line officers hesitate to request

[7] In this connection, a memorandum dated 30 December 1943 from Gen. George C. Marshall, Chief of Staff, to Maj. Gen. Alexander D. Surles is of great interest (p. 131).

Section VIII Board proceedings in the case of unfit soldiers feeling that it is an admission of failure on their part because they cannot train and develop good soldiers in individuals of these types.

Major Farrell recommended consideration of giving these individuals disability discharges since they were psychiatric problems. Hecker and his associates [8] also suggested this be done routinely because company commanders lacked the time to accomplish the rather complicated procedure required for section VIII (AR 615–360) boards.[9]

It was not unusual for a medical officer to succumb to the friendly overtures of a company commander "to get rid of so and so" who was a problem in the company. "Getting rid of" generally meant sending him to the hospital. When a liberal discharge policy was in effect, sending a man to the hospital for a psychiatric disorder was practically tantamount to giving him a medical discharge.

In oversea theaters where the question of discharges was not one of primary concern, it was a matter of evacuating such cases to the United States. In the Pacific theaters where the manpower situation did not permit liberal evacuation policies, there was relatively little such abuse of medical channels. There and in the North African-Mediterranean theater, directives had been issued which restricted such abuses. In the European theater where the major portion of the oversea Army was located, patients with mental deficiency and those with psychopathic personalities were often, if not routinely, admitted to hospitals and medically evacuated to the United States. Upon arrival in the Zone of Interior hospital, disposition was extremely difficult. Evidence of lack of adaptability, and so forth, which was contained in the abbreviated accompanying medical records was not sufficient in most instances to convince a board of line officers that administrative discharge was appropriate for a soldier who had served overseas and had been evacuated as a patient.

Discharge for the Convenience of the Government

In December 1942, additional efforts were made to dispose of marginal personnel. It was directed [10] that limited-service enlisted personnel who could not read or write the English language as commonly prescribed for the fourth grade in grammar school and who did not meet one of the following qualifications be discharged for the convenience of the Government (sec. X, AR 615–360), when in the best interests of the military service:

1. He must possess a civilian occupational skill which is needed by the Army and which the man is physically capable of performing, or

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[8] Hecker, A. O., Plesset, M. R., and Grana, P. C.: Psychiatric Problems in Military Service During Training Period. Am. J. Psychiat. 99: 33–41, July 1942.

[9] The recommendations of Farrell and of Hecker and his associates were never seriously considered because of the experience after World War I when a disability discharge carried with it an excellent chance of receiving disability compensation from the Veterans' Administration although, in the opinion of physicians, it was not warranted in many instances.—N. Q. B.

[10] War Department Circular No. 395, 5 Dec. 1942.

2. He must possess sufficient intelligence and education to absorb instructions and attain a skill rapidly and to be physically capable of performing the duties attendant to such skill, or

3. He must be physically capable of performing manual labor day after day.

The same criteria were adopted for the induction of limited-service personnel.

Trend Toward Elimination

Reports were received from oversea commanders to the effect that too many men who were mentally unsuited for ordinary military duties were arriving overseas. They indicated that in many instances these individuals had been observed in Army hospitals in the United States only to be returned to duty. Accordingly, on 25 March 1943, the following directive was issued: [11]

> Great care will be taken by all medical officers at induction stations, hospitals, replacement training centers, tactical units, staging areas, and ports of embarkation to make certain that everything possible is done to prevent * * * misfits from entering the service and especially from being sent overseas. Every effort will be made to detect and eliminate these individuals before they reach the staging area. These cases are disturbing to the morale and discipline of a unit. They present a problem and an unnecessary burden to unit commanders, often requiring that they be returned to this country after a brief period of service overseas.
>
> All concerned will give careful consideration to the detection and the prevention of return to duty for service overseas of cases of psychoneurosis, mental deficiency, epilepsy, constitutional psychopathic state, and psychoses. The detection of these mentally abnormal cases before their shipment out of this country is an extremely important duty of each medical officer, since the elimination of such individuals will enhance materially the efficiency of oversea organizations.

This directive was superseded by a stronger one [12] about a month later, to the following effect:

> 1. Greater care will be taken by all medical officers at induction stations to make certain that everything possible is done to prevent all individuals predisposed to or suffering from psychoneurosis, mental deficiency, constitutional psychopathic state, epilepsy, psychosis, organic disease of the nervous system or having a proven history of these conditions from entering the military service. Attention is invited to the fact that there is no classification for duty of military personnel with such mental diagnoses as psychoneurosis, mental deficiency, epilepsy, constitutional psychopathic state, and psychosis.
>
> 2. Medical officers of all units, especially those at training centers, hospitals, tactical units, staging areas, and ports of embarkation, will increase their efforts to detect individuals with the conditions mentioned in paragraph 1 with a view to the discharge of those who cannot be expected to render full military duty.

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[11] War Department Memorandum No. W600–30–43, 25 Mar. 1943.

[12] War Department Memorandum No. W600–39–43, 26 Apr. 1943.

Solution by Medical Discharge

From the foregoing, it seemed that the decision relative to which neuropsychiatric patients were capable of performing duty was taken out of the hands of the medical officers and assumed by higher authority. The directives by higher authority literally invited a witch hunt for the elimination of all persons with any taint of an emotional disorder, contrary to the recommendation of the Neuropsychiatry Consultants Division, SGO (Surgeon General's Office), and made their discharge (generally for disability) mandatory. Also, articles written by psychiatrists, civilian and military, pointed to World War I experience, and General Pershing's famous telegram (p. 154) (requesting that no one with any evidence of emotional instability be sent overseas) was often quoted. Reference was made to the large amount of money which was spent by the Government to provide care for neuropsychiatric patients after the war, and pleas were made to avoid getting involved again. The effect of this announced War Department policy was to increase greatly hospital admissions and disability discharges for psychoneuroses. Dr. Eli Ginzberg, a special assistant to The Surgeon General and chief of the Resources Analysis Division, SGO, commenting on this, stated:

> Problems of morale, induction and separation and rotation were handled by officers of the line who were so oblivious to the psychiatric aspects of their problems that they failed to seek, no less follow, professional advice.[13]

Impact of Liberal Disposition Policy

Although not documented, there were medical officers, including psychiatrists, who were of the opinion that many individuals with psychoneuroses were capable of performing effective duty and who by various subterfuges tried to prevent their discharge. These psychiatrists would avoid making a diagnosis of psychoneurosis whenever possible. They would first decide whether or not a man was capable of doing duty and then supply a diagnosis which would permit such a disposition. If the case happened to be one of psychoneurosis, a term such as "simple adult maladjustment" or "situational maladjustment" might have been employed.[14] To repeat, free use was made of such diagnoses as gastritis for cases of functional vomiting, lumbosacral strain for cases of functional backaches, and cephalalgia for cases of tension or hysterical headaches. Other medical officers often did not request psychiatric consultations for fear the psychiatrist would make a diagnosis of psychoneurosis.

Strangely enough, the psychiatrists came in for a great deal of indirect criticism and blame for the policy which they had no part in initiating. It

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[13] Ginzberg, E.: Logistics of the Neuropsychiatric Problem of the Army. Am. J. Psychiat. 102: 728–731, May 1946.

[14] One wonders whether the diagnosis of a transient type of disorder was not correct and indeed not a subterfuge.—A. J. G.

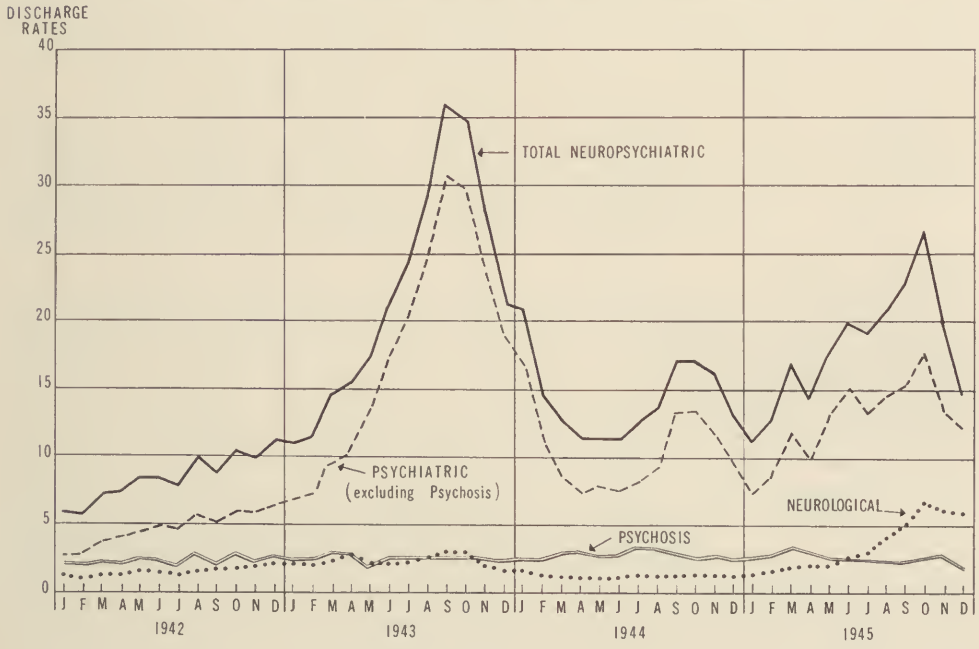
was felt that they were using the diagnosis of psychoneurosis too freely when all they were trying to do was to apply the criteria which they had been taught in civilian life. From the beginning, the Neuropsychiatry Consultants Division had opposed the policy of indiscriminate discharge of patients with neuropsychiatric disorders, but their efforts were in vain. It seemed that many medical officers (and the Army, in general) were not aware of the prevalence of emotional disorders, and they could not understand the phenomenon which was before them—the increasing number of individuals who were hampered or crippled by their emotions.[15]

Elimination of Limited Service

Up until this time, the major emphasis had been placed on preventing men with neuropsychiatric disorders from going overseas (although the Medical Department was encouraged to eliminate as many as possible from the service). Despite the directive which emphasized the fact that there was no classification duty for patients with neuropsychiatric disorders (p.

CHART 1.—*Discharge rates of enlisted men on certificate of disability for discharge for neuropsychiatric conditions, U.S. Army, by year and month, 1942–45*

[Rate expressed as number of enlisted men discharged per 1,000 mean strength per year]



[15] In retrospect, some of the criticisms directed toward psychiatrists seem justified. Many Army psychiatrists could not alter their attitudes based on civilian experience and considered situational maladjustments and immature reactions to be identical with the fixed neuroses of civilian life.—A. J. G.

201), large numbers of men had been returned (and were still being returned) to limited duty in overhead installations. As more and more men were transferred from field force units for limited duty, more than could be utilized accumulated in the United States.

In July 1943, the War Department completely eliminated the category "limited service." [16] It was ordered that all those who did not meet the minimum standards for induction would be discharged. Exceptions could be made in those cases where men were physically qualified to perform their present assignments provided their commanding officers desired to retain them. While commanders of all echelons were directed to "exercise close personal supervision in appraising the soldier's physical qualifications, prior training, skills, intelligence, and aptitude to assure the fullest utilization of the soldier's potential capabilities," the effect of this circular was to initiate an Army-wide house cleaning. Thousands of men who had been classified as "limited service," in many instances for disabilities which were

TABLE 2—*Disability discharges for neuropsychiatric conditions, by diagnosis and year, U.S. Army, worldwide, 1942-45*

[Rate expressed as number of individuals separated or discharged per 1,000 mean strength per year]

Diagnosis	Total 1942–45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
	Total U.S. Army Personnel									
Neurological disorders:										
Epilepsy	15,103	0.6	2,589	0.8	5,398	0.8	3,940	0.5	3,176	0.4
Other	37,097	1.5	2,214	.7	11,608	1.7	9,176	1.2	14,099	1.9
Total	52,200	2.1	4,803	1.5	17,006	2.5	13,116	1.7	17,275	2.3
Psychiatric disorders:										
Psychosis	62,062	2.5	7,013	2.2	15,831	2.3	19,279	2.5	19,939	2.7
Psychoneurosis	268,744	10.6	14,159	4.4	105,544	15.4	66,757	8.5	82,284	11.1
Character and behavior disorders	3,163	.1	401	.1	1,021	.1	1,006	.1	735	.1
Disorders of intelligence	2,653	.1	709	.2	1,250	.2	467	.1	227	.0
Other psychiatric disorders	337	.0	1	.0	71	.0	164	.0	101	.0
Total	336,959	13.3	22,283	6.9	123,717	18.0	87,673	11.2	103,286	13.9
Total neuropsychiatric disorders	389,159	15.4	27,086	8.4	140,723	20.5	100,789	12.9	120,561	16.2

[16] War Department Circular No. 161, 14 July 1943.

TABLE 2—*Disability discharges for neuropsychiatric conditions, by diagnosis and year, U.S. Army, worldwide, 1942-45*—Continued

[Rate expressed as number of individuals separated or discharged per 1,000 mean strength per year]

Diagnosis	Total 1942-45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
	Enlisted Men									
Neurological disorders:										
Epilepsy	14,633	0.6	2,559	0.9	5,258	0.8	3,735	0.5	3,081	0.5
Other	35,472	1.6	2,162	.7	11,328	1.9	8,571	1.3	13,411	2.0
Total	50,105	2.2	4,721	1.6	16,586	2.7	12,306	1.8	16,492	2.5
Psychiatric disorders:										
Psychosis	59,935	2.6	6,859	2.3	15,320	2.4	18,542	2.7	19,214	3.0
Psychoneurosis	259,432	11.4	13,806	4.6	102,737	16.4	63,320	9.0	79,569	12.3
Character and behavior disorders	2,930	.1	357	.1	931	.2	952	.1	690	.1
Disorders of intelligence	2,650	.1	709	.2	1,249	.2	465	.1	227	.0
Other psychiatric disorders	281	.1	1	.0	55	.0	141	.0	84	.0
Total	325,228	14.2	21,732	7.2	120,292	19.2	83,420	11.9	99,784	15.4
Total neuropsychiatric disorders	375,333	16.4	26,453	8.8	136,878	21.9	95,726	13.7	116,276	17.9

NOTE.—A rate of 0.0 denotes less than 0.05.

Source: Individual Medical Records. The presented data for enlisted men somewhat differ from those published in "Health of the Army," vol. 1, Report Number 2, 31 Aug. 1946, which were preliminary data based on individual reports received from the Office of The Adjutant General. (See also appendix A, table 9.)

not serious and often for psychoneuroses which may have been transient, were admitted to hospitals and discharged from the Army on certificate of disability for discharge. Many others, not previously classified limited service, were placed on limited service (for psychoneuroses more often than any other condition) and then discharged. Competent medical technicians in station hospitals who, although classified "limited service," were doing superior work got caught in the increasing stream of discharges and soon found themselves out of the Army as "disabled soldiers." WD (War Department) Memorandum No. W615–64–43 (26 August 1943) called attention to the fact that commanders were authorized to retain individuals not meeting standards, whose services were such as to warrant retention.

The effects of these changing policies with respect to neuropsychiatric patients are clearly reflected in tables 2 and 3, where the discharge rates for disability because of neuropsychiatric disorders are presented for

World War II by year and month, respectively. Some 389,000 military persons were discharged during World War II for neuropsychiatric disorders. Some 375,000 of these persons were enlisted men, discharged on certificate of disability for discharge. From a yearly disability discharge rate of 8.8 per 1,000 mean strength per year (enlisted men) in 1942, the discharge rate rose to 21.9 in 1943; it declined to 13.7 in 1944, and rose again to a rate of 17.9 in 1945 (table 2). These wide fluctuations in the discharge rates appear even more conspicuous when viewed on a month to month basis. The discharge rate reached alarming heights in September 1943, when it rose to a rate of 35.6 per 1,000 mean strength per year (table 3). (See also chart 1 for discharge rates by month.)

TABLE 3.—*Discharge rates* [1] *of enlisted men on certificates of disability for discharge for neuropsychiatric conditions, by broad diagnostic categories and month, U.S. Army, worldwide, 1942–45*

[Rate expressed as number of enlisted men discharged per 1,000 mean strength per year]

Year and month	Diagnosis				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1942					
January	5.7	1.2	4.5	2.0	2.5
February	5.5	.9	4.6	1.9	2.7
March	7.0	1.2	5.8	2.2	3.6
April	7.3	1.4	5.9	2.0	3.9
May	8.4	1.6	6.8	2.4	4.4
June	8.4	1.5	6.9	2.2	4.7
July	7.6	1.3	6.3	1.8	4.5
August	9.7	1.5	8.2	2.7	5.5
September	8.6	1.5	7.1	2.0	5.1
October	10.2	1.7	8.5	2.7	5.8
November	9.9	1.8	8.1	2.3	5.8
December	11.0	2.1	8.9	2.5	6.4
1943					
January	10.9	2.1	8.8	2.2	6.6
February	11.3	1.9	9.4	2.3	7.1
March	14.3	2.2	12.1	2.6	9.5
April	15.2	2.5	12.7	2.5	10.2
May	17.0	2.0	15.0	1.9	13.1
June	21.2	2.0	19.2	2.1	17.1
July	24.0	2.1	21.9	2.1	19.8
August	28.8	2.4	26.4	2.0	24.4
September	35.6	2.9	32.7	2.1	30.6
October	34.6	2.8	31.8	2.4	29.4
November	27.1	1.9	25.2	2.1	23.1
December	21.7	1.6	20.1	2.0	18.1

See footnote at end of table, p. 207.

TABLE 3.—*Discharge rates* [1] *of enlisted men on certificates of disability for discharge for neuropsychiatric conditions, by broad diagnostic categories and month, U.S. Army, worldwide, 1942–45* —Continued

[Rate expressed as number of enlisted men discharged per 1,000 mean strength per year]

Year and month	Diagnosis				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1944					
January	20.3	1.7	18.6	2.2	16.4
February	14.3	1.3	13.0	2.3	10.7
March	12.3	1.3	11.0	2.7	8.3
April	11.0	1.0	10.0	2.8	7.2
May	11.0	1.0	10.0	2.5	7.5
June	11.0	1.0	10.0	2.6	7.4
July	12.2	1.1	11.1	3.3	7.8
August	13.0	1.2	11.8	3.0	8.8
September	16.8	1.2	15.6	2.5	13.1
October	16.6	1.2	15.4	2.3	13.1
November	15.5	1.4	14.1	2.5	11.6
December	12.8	1.2	11.6	2.3	9.3
1945					
January	10.8	1.4	9.4	2.4	7.0
February	12.2	1.5	10.7	2.5	8.2
March	16.5	2.0	14.5	3.1	11.4
April	13.9	1.8	12.1	2.6	9.5
May	17.4	2.2	15.2	2.3	12.9
June	19.6	2.6	17.0	2.3	14.7
July	18.4	2.7	15.7	2.4	13.3
August	20.3	3.7	16.6	2.2	14.4
September	22.2	4.9	17.3	2.0	15.3
October	26.1	6.5	19.6	2.3	17.3
November	18.9	5.9	13.0	2.5	10.5
December	14.2	5.8	8.4	1.7	6.7

[1] Based on individual reports of discharges for disability furnished by the Office of The Adjutant General. (See "Health of the Army," vol. 1, Report No. 2, 31 Aug. 1946.)

These data are particularly significant in view of the fact that the CDD's (enlisted men) for neuropsychiatric disorders constituted between 40 percent (in 1943) and 49 percent (in 1944) of all CDD's (table 4, "Enlisted Men").

REVERSAL OF LIBERAL DISCHARGE POLICY

It became apparent that a continuation of the policy of discharging limited-service personnel would be disastrous. The pendulum then did swing in the opposite direction, clamping down on all discharges. On 3

TABLE 4.—*Relationship between discharges for disability for neuropsychiatric conditions and disability discharges for all nonbattle diseases and injuries, U.S. Army, worldwide, 1942–45* [1]

[Rate expressed as number of individuals separated or discharged per 1,000 mean strength per year]

Diagnosis	Neuropsychiatric disability discharges as percent of all disability discharges, by year				
	Total 1942–45	1942	1943	1944	1945
	Total U.S. Army Personnel				
Neurological disorders:					
Epilepsy	1.7	4.1	1.5	1.9	1.2
Other	4.2	3.5	3.3	4.5	5.2
Total	5.9	7.6	4.8	6.4	6.4
Psychiatric disorders:					
Psychosis	7.0	11.1	4.5	9.5	7.4
Psychoneurosis	30.3	22.3	30.1	32.9	30.6
Character and behavior disorders	.4	.6	.3	.5	.3
Disorders of intelligence	.3	1.1	.4	.2	.1
Other psychiatric disorders	.0	.0	.0	.1	.0
Total	38.0	35.1	35.3	43.2	38.4
Total neuropsychiatric disorders	43.9	42.7	40.1	49.6	44.8
	Enlisted Men				
Neurological disorders:					
Epilepsy	1.7	4.1	1.5	1.9	1.2
Other	4.1	3.5	3.3	4.4	5.1
Total	5.8	7.6	4.8	6.3	6.3
Psychiatric disorders:					
Psychosis	6.9	11.1	4.4	9.6	7.3
Psychoneurosis	30.1	22.3	29.8	32.7	30.4
Character and behavior disorders	.4	.6	.3	.5	.3
Disorders of intelligence	.3	1.1	.4	.2	.1
Other psychiatric disorders	.0	.0	.0	.1	.0
Total	37.7	35.1	34.9	43.1	38.1
Total neuropsychiatric disorders	43.5	42.7	39.7	49.4	44.4

[1] See "Note" and "Source" to table 2.

November 1943, the following War Department radiogram was sent to all service commands:

> Pending imminent publication of War Department circular covering subject of utilization of military manpower based upon physical capacity provisions * * * (of previous War Department directives) are suspended. Discharges and processing for discharge under the provisions of these publications will cease immediately and will be resumed only on receipt of and under the provisions of forthcoming circular mentioned above. Desire you advise commanding officers of all stations within territorial limits your service command by most expeditious means.

The revised policy was issued 8 days later, on 11 November 1943, in WD Circular No. 293, entitled "Enlisted Men—Utilization of Manpower Based on Physical Capacity."

All previous instructions were rescinded, and emphasis was placed on the salvaging and utilization of every man possible. (This was approximately 2 months after Allied Forces had invaded southern Italy and at the time when there was heavy fighting around the Volturno River, south of Cassino.) It was pointed out: "Classification, assignment, reassignment, and training are command functions which must be exercised energetically and continuously so that the skill, aptitude, physical qualifications, and capacity for development of the individual are used to the utmost."

Salvage and Utilization

The circular also pointed out that many positions in the Army (including combat units) do not require men of unusual strength and physical ability. In line with the new policy of conserving manpower, enlisted men who were in assignments which demanded more physical endurance than they were capable of were to be reassigned jobs within their capacities. It was recognized that many men were extremely valuable to the Army because of their training and experience despite the fact that they were below the physical standards for induction. The discharge of an enlisted man for physical reasons because he was incapable of serving in a physically exacting position when he was able to render adequate service in a less exacting assignment was prohibited. Such men were to be retained in the service and given appropriate assignments even though they did not fulfill the minimum physical standards for induction under MR (Mobilization Regulations) 1–9.

The unnecessary removal of trained enlisted men from units immediately before departure for overseas was pointed out as a flagrant example of wastage of military manpower and training, destructive alike to the morale of the individual and the efficiency of the unit.

The existence of a nonprogressive or remediable defect or disease which would disqualify a man for dispatch overseas was not considered sufficient reason to return him to the United States from an oversea theater. Men whose defects were such that they could be remedied within the

oversea command and those who could serve usefully in any assignment in an oversea theater, despite their defects, were to be retained.

The discharge of men who were able to render effective service was prohibited. On the other hand, the retention of men unable to perform a reasonable day's work for the Army was considered wasteful. Commanders and surgeons were advised to exercise extreme care and judgment in arriving at a decision to discharge an enlisted man on physical grounds. It was directed that commanders exercising discharge authority give this matter their closest personal supervision so as to obtain the maximum benefit from available manpower.

Enlisted men were to be assigned to the most active type of duty appropriate to their physical qualifications with due consideration to their civilian training and experience, education, intelligence, aptitude, leadership ability, and acquired military occupational qualifications. The need for all commanders and those staff officers concerned with personnel to study this matter continuously was emphasized.

The use of the term "limited service" pertaining to enlisted men was discontinued. (This term was to be used only at Armed Forces induction stations where similar terminology was used by Selective Service and the Navy.) Discontinuance of the term "limited service," however, did not mean that men who were classified as limited service were to be discharged or that the Army would not continue to induct and use men who do not meet the full standards for general service.

No longer were individuals with neuropsychiatric disorders to be discharged routinely. Any man capable of performing any type of duty was to be retained, and the responsibility for the proper assignment of men with limited capacities was placed on command. Pronounced psychiatric disorders were, however, still considered disqualifying for oversea service, and men with other psychiatric disorders, except mild psychoneuroses, transient in character, although eligible for oversea service were not to be assigned to combat organizations.

Surgeon General's Office Policy

Up until this time, the views of the Neuropsychiatry Consultants Division, SGO, had not been accepted or included in the formulation of War Department discharge policies. With the change in policy to one of "conservation of manpower," they were accepted and published as a Surgeon General's circular letter[17] which stated that separation from the service would not be recommended merely because a man has or has had a psychoneurosis or similar psychiatric disorder. Going even further than the policy announced by the War Department, it said that men with psychoneuroses could be recommended for combat service if they were believed capable of it. The importance of evaluating each case individually was stressed. Where

[17] Circular Letter No. 194, Office of The Surgeon General, U.S. Army, 3 Dec. 1943.

the psychiatric disorder was believed to arise more from indifference toward the war than from fundamental instability of personality, the individual was to be retained for service. It was pointed out that a large proportion of men developing psychiatric disorders, particularly in combat zones, if properly treated and promptly returned to duty, recover entirely and render valuable service.

The significance of this directive cannot be overemphasized. It was the first time that The Surgeon General had expressed a policy which varied from the old concept that "all NP's were no good." Much effort was to be expended later in maintaining its principles.

Army Service Forces Policy

On 8 January 1944, to emphasize the new policy, Lt. Gen. Brehon B. Somervell, Commanding General, ASF (Army Service Forces), issued the following letter on the utilization of available manpower:

1. The following personal directive of the Chief of Staff (General Marshall) is quoted:

Reports are continually being received that large numbers of men are being discharged for physical or mental reasons, that units are discarding considerable percentages of their strengths on similar ground, and that physically qualified personnel are being used in limited service positions. The serious wastage resulting must in part be charged to a failure on the part of commanders to exercise a rigid personnel economy. Since physically perfect men are not available in the quantities desired, the Army must be maintained with the personnel at hand and it rests with the commander to do so. A unit commander who permits the discharge of an enlisted man in preference to making the necessary effort to properly place and train him fails to meet his responsibilities.

There are also indications of failure to place sufficient emphasis upon the preventative maintenance of the individual. Training in mental and physical hygiene, sanitation, and other preventive measures must be intensified. Unit commanders whose inadequate leadership is reflected in a high preventable sick rate, or a high rate of discharge, or transfer for physical or mental reasons must be replaced.

The present manpower situation is critical. Industrial as well as armed force requirements are pressing and must be met. We are now receiving from Selective Service men who hitherto have been deferred for dependency reasons. The country cannot afford, nor can the Army tolerate, any wastage of suitable manpower. The solution lies in the proper exercise of command functions and it is desired that this matter be given personal and continuing attention.

2. You will furnish copies of this letter to each officer under your jurisdiction. Further, you will require each commander of a lower echelon to study this letter and to take every necessary measure to comply energetically and continuously with the letter and spirit of the instructions contained herein and in Circular 293, War Department, 11 November 1943. As an additional means of indoctrinating our commissioned personnel, this headquarters will schedule instruction in the proper utilization of manpower in the program for each officers' school and officer candidate school.

3. You are charged with close supervision of this program.

The recognition that health was a responsibility of command was an extremely significant development. As long as it remained the sole responsibility of the Medical Department, there were great limitations on what could be done in a preventive way.

This was reemphasized in WD Circular No. 164, issued on 26 April 1944, subject: Enlisted Men—Use of Manpower Based on Physical Capacity (as amended by WD Circular No. 212, 29 May 1944).

Reaccumulation of Marginal Personnel

The immediate effect on all these directives was apparent. Discharges dropped off precipitously. In some instances, the provisions of the directives were followed so rigidly that men who were capable of performing only a few hours' work a day in sedentary jobs were returned to or retained on duty.

From its peak in September 1943 (a rate of 35.6), the disability discharge rate for neuropsychiatric disorders dropped to 11.0 per 1,000 mean strength per year in April 1944; it stabilized at that level for at least two more consecutive months (May and June, 1944) (table 3). In absolute numbers, from 19,500 enlisted men discharged for neuropsychiatric disorders in September 1943 and again in October of that year, the number gradually declined to 6,400 in April 1944.

Once again, men with limited capacities accumulated in the Army in increasing numbers. In 1944, the war was progressing favorably. The Russians were advancing westward, Cassino fell to the Allied forces, and in June, Normandy was invaded. Paris was liberated in the latter part of August, and in September, U.S. troops entered Germany. A wave of optimism spread over the country, and rumor in the War Department set November as the time Germany would surrender.

By April through June 1944, the neuropsychiatric discharge rate was somewhat less than one-third of what it was at its highest level in 1943. However, as a result of the invasion of Normandy and the subsequent heavy fighting, hospitals in the European theater were beginning to fill up.[18] Increasing numbers of patients were expected to start arriving in the States in the fall of 1944. Indeed, the expected increase started in December 1944. From 4,200 patients evacuated from overseas in November 1944, the number rose to about 7,800 in December 1944, and reached its high point in May 1945 when somewhat over 9,500 patients were evacuated from oversea theaters to the United States. During this period, the evacuation rate for neuropsychiatric disorders fluctuated between 12 and 23 per 1,000 mean strength per year. The evacuees for neuropsychiatric disorders constituted during this period between 25 and 17 percent of all evacuees. For the entire World War II, the percentage of neuropsychiatric evacuees was about 21 percent of all evacuees—an unquestionably high percentage. (See table 5.)

In addition, rigid adherence to the policy of salvaging manpower resulted in the retention of many men who were not capable of performing effective duty. Since there were a limited number of jobs in garrison

[18] The total number of neuropsychiatric patients remaining in hospitals overseas (all theaters) rose from 7,904 in January 1944 to a peak of 18,834 in December 1944.

installations in the Zone of Interior to which they could be assigned, increasing numbers of those who were returned to duty from hospitals in the Zone of Interior were readmitted after short periods of inactivity or trial at duty and, again, pressure began to be exerted to lower the discharge standards.

TABLE 5.—*Neuropsychiatric patients evacuated from overseas, by month, 1943–45*

[Rate expressed as number of evacuees per 1,000 mean strength per year]

Year and month	Neuropsychiatric patients evacuated			Year and month	Neuropsychiatric patients evacuated		
	Number	Evacuation rate	Percent of total evacuees		Number	Evacuation rate	Percent of total evacuees
1943				*1944*—Con.			
January	477	5.8	18.7	September	4,125	13.0	23.2
February	211	2.4	9.2	October	2,657	8.0	15.2
March	345	3.6	13.9	November	4,200	12.1	23.5
April	1,105	10.8	22.2	December	7,792	21.4	24.9
May	842	7.7	16.0				
June	780	6.5	15.1	Total	43,658	12.5	26.9
July	957	7.3	18.7				
August	1,566	11.0	19.9	*1945*			
September	1,996	13.3	20.8	January	6,699	17.5	20.0
October	1,416	8.5	18.9	February	7,023	17.5	18.6
November	2,109	11.7	24.0	March	7,792	19.2	17.3
December	937	4.7	12.1	April	8,371	20.2	19.9
				May	9,549	22.8	16.9
Total	12,741	8.2	18.4	June	6,389	15.7	15.1
				July	6,923	18.0	18.6
1944				August	5,975	17.2	23.1
January	2,370	11.2	31.7	September	4,762	15.6	26.1
February	3,050	13.6	31.0	October	3,167	11.4	16.6
March	3,100	12.6	35.1	November	2,878	12.6	21.1
April				December	1,733	10.7	19.0
May	[1] 9,730	11.7	36.3				
June				Total	71,261	17.2	18.7
July	3,084	10.4	27.1				
August	3,560	11.1	26.2	Grand total	127,660	13.9	20.9

[1] No monthly data are available for neuropsychiatric evacuees during this 3-month period.

LIBERAL DISCHARGE POLICY REESTABLISHED

A followup study was made in June 1944 by the Surgeon General's Office to determine the effectiveness, as reported by their commanding officers, of neuropsychiatric patients who were being returned to duty from general and station hospitals in the Zone of Interior, with recommendations for special assignments. The findings, based on 47 percent of the entire group on whom reports were recorded, were as follows:

In 26 percent of the patients, the adjustment was considered excellent. About 42 percent were rated satisfactory, and the remaining 32 percent were rated poor. In 30 percent of all cases, commanding officers believed that discharge from the service was indicated. There was evidence to indicate that some of the men who were rated unsatisfactory were improperly assigned.[19]

With these facts in mind, on 23 August 1944, a letter was sent to all service commands by Brig. Gen. Raymond W. Bliss, Chief, Operations Service, SGO, inviting some liberalization of neuropsychiatric discharges. This letter was sent out without the knowledge of the Neuropsychiatry Consultants Division and contrary to the known opinion of that division.

This was followed shortly by a War Department letter, dated 8 September 1944, drawing attention to a forthcoming War Department circular (WD Circular 370) to the following effect: That the retention of personnel who did not meet the minimum physical induction standards for limited service as prescribed by MR 1–9 for whom there were no appropriate authorized positions to which they could be assigned was not desired. Any degree of psychoneurosis was considered below minimum induction standards for limited service at that time.

Also at this time, the Army was criticized by Congress for retaining more men than it needed. Supposedly, it was over its quota. In addition, the directors of the Hospital Division and Resources Analysis Division were of the opinion that liberalizing discharges would reduce the number of readmissions to hospitals and thereby increase the number of available beds.

Again, the plan was to utilize medical discharges to decrease the size of the Army. War Department Circular No. 370 was issued on 12 September 1944. It authorized the discharge and the return from overseas for discharge of the aforementioned type of personnel who did not meet the minimum physical induction standards. The determination was to be made in each case whether discharge was to be for disability (CDD) or for the convenience of the Government.

Indiscriminate Medical Discharges Opposed

The Neuropsychiatry Consultants Division was opposed to any liberalization of medical discharges. Its opinion was that the criteria for disability discharges should remain constant. If the War Department wanted to decrease the size of the Army or the size of the limited-service pool, it should be accomplished by administrative procedures. The indiscriminate use of disability discharges which had been experienced the year before had wasted manpower, resulted in abuse of the diagnosis of psychoneurosis, and, in the opinion of many, had undermined morale.

To forestall a repetition of this, an implementing directive[20] was is-

[19] Monthly Progress Report, Army Service Forces, War Department, July 1944, Section 7: Health.
[20] Army Service Forces Circular No. 318, 23 Sept. 1944.

sued, primarily at the insistence of the Neuropsychiatry Consultants Division. It restricted the use of medical discharge to those who were actually disabled for service. It emphasized the need for medical officers to distinguish between defects which did not preclude doing duty and those which were truly incapacitating. Those who were capable of performing limited-service duties were ordinarily to be discharged for the convenience of the Government and not for disability. It was specifically stated that mild

CHART 2.—*Admission rates for neuropsychiatric disorders, U.S. Army, by year and month, 1942–45*

[Rate expressed as number of admissions per 1,000 mean strength per year]

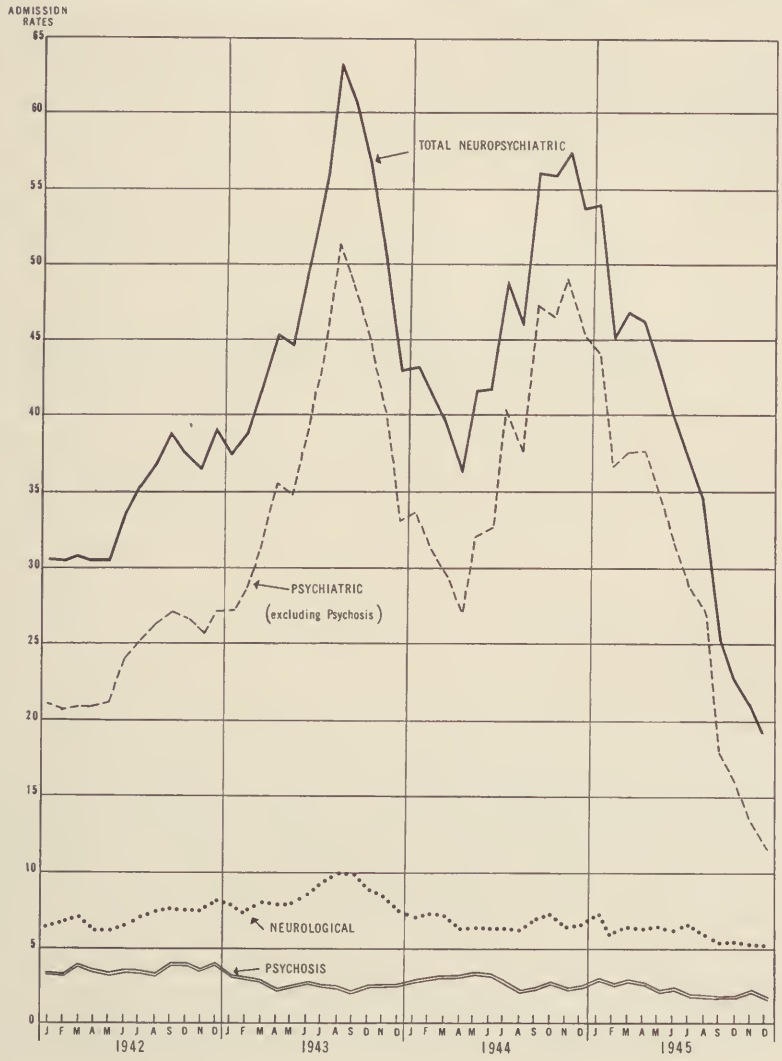


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TABLE 6.—*Admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, worldwide, 1942–45*[1]

[Rate expressed as number of admissions per 1,000 mean strength per year]

Diagnosis	Total 1942–45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Neurological disorders:[2]										
Epilepsy	18,077	0.7	4,115	1.3	6,542	1.0	4,465	0.6	2,955	0.4
Other	156,345	6.2	18,344	5.6	50,636	7.3	46,080	5.9	41,285	5.6
Total neurological disorders	174,422	6.9	22,459	6.9	57,178	8.3	50,545	6.5	44,240	6.0
Psychiatric disorders:										
Psychosis	67,642	2.7	11,310	3.5	17,527	2.6	21,900	2.8	16,905	2.3
Psychoneurosis	648,500	25.6	53,933	16.7	199,162	28.9	232,335	29.9	163,070	22.0
Character and behavior disorders:										
Pathological sexuality	5,455	0.2	569	0.2	1,826	0.3	1,920	0.2	1,140	0.2
Asocial and antisocial personality types	2,715	.1	278	.1	497	.1	685	.1	1,255	.2
Immaturity reaction[3]	66,455	2.6	7,505	2.2	21,215	3.0	20,945	2.6	16,790	2.2
Alcoholism	42,044	1.7	7,182	2.2	10,962	1.6	11,530	1.5	12,370	1.6
Acute	(30,946)	(1.2)	(5,450)	(1.7)	(7,911)	(1.2)	(8,430)	(1.1)	(9,155)	(1.2)
Chronic	(11,098)	(.4)	(1,732)	(.5)	(3,051)	(.4)	(3,100)	(.4)	(3,215)	(.4)
Drug addiction	1,295	.1	171	.1	559	.1	430	.1	135	.0
Enuresis	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	560	.1	470	.1
Total	118,994	4.7	15,705	4.8	35,059	5.1	36,070	4.6	32,160	4.3
Disorders of intelligence	28,871	1.1	4,083	1.3	14,113	2.1	7,360	0.9	3,315	0.4
Other psychiatric disorders	64,638	2.6	6,565	2.0	18,048	2.6	19,605	2.5	20,420	2.7
Total psychiatric disorders	928,645	36.7	91,596	26.3	283,909	41.3	317,270	40.7	235,870	31.7
Total neuropsychiatric disorders	1,103,067	43.5	114,055	35.2	341,087	49.6	367,815	47.2	280,110	37.7

[1] The diagnostic nomenclature and classification used for the presentation of World War II data on morbidity, separation, and mortality are those adopted by the Army in 1944 and used for 1944 and 1945 records. Therefore, the data for diseases which in 1942 and 1943 were differently named or classified, or both, were translated and, in effect, reclassified or renamed in equivalent or closely equivalent terms of the 1944–45 diagnostic classification and nomenclature. In certain cases, this involved a major relocation. With respect to psychiatric diagnoses, cases of "alcoholism," for instance, while separately identified prior to 1944 as "alcoholism with psychosis" and "alcoholism without psychosis," appeared in the broad class of "General Diseases" and not in the "Nervous System" class, where neuropsychiatric disorders have been shown. Under the 1944–45 classification, alcoholism with psychosis was included under "psychosis," and the other cases of alcoholism were classified under "Character and Behavior Disorders," separately by acute and chronic alcoholism. Similarly, cases of "Drug Addiction," previously classified under "General Diseases," are shown here under "Character and Behavior Disorders." "Enuresis" presented in this respect a more complex problem, as no distinction was made prior to 1944 between "enuresis"—a "habit" reaction symptomatic of immaturity—and "enuresis"—a symptom of some organic disorder. (Prior to 1944, all cases of enuresis were listed in the "Genitourinary Disease" class.) The 1944–45 nomenclature provided for such a differentiation, listing "enuresis" symptomatic of immaturity under "Character and Behavior Disorders," and the other type of enuresis under "General and Miscellaneous Diseases." Inasmuch as no differentiation could be made with respect to the data on enuresis prior to 1944, all cases of enuresis in 1942 and 1943 were translated to the 1944–45 class of "General and Miscellaneous Diseases." (The table carries, therefore, for 1942 and 1943 the symbol NA—not available—for

psychoneuroses would not be considered adequate cause for discharge on certificate of disability.

This represented a second and final attempt to prevent the War Department from encouraging the utilization of medical discharges as a means of controlling the size of the Army or the number of men on limited service.[21] For the first time, it was pointed out that disability discharges were intended for those who were disabled—a concept which apparently had been overlooked previously. It was not uncommon to hear voiced the opinion: "They'll all get pensions anyway, so what difference does it make how you discharge them." The psychological effect of discharging a man as "disabled" seemed to be a matter of no concern. Brig. Gen. William C. Menninger,[22] in reviewing the problems confronting psychiatry in the Army convalescent hospital, commented on this, as follows:

> In every convalescent hospital there is a basis to state that we are going to have from 15 to 25 percent of the patients on the NP Section that we do not regard as "sick" * * *. We still do not believe he should be rewarded for his noneffectiveness by the award of a certificate of disability. We must face realistically the mental hygiene aspect of the problem when the man is discharged from the hospital as an "invalid" and then is subsequently paid to stay sick.

As a result of WD Circular No. 370 (September 1944), the hospital admission and admission rates for neuropsychiatric disorders reached another peak, in the late months of 1944 and the early months of 1945. (The first peak occurred in the second half of 1943, tables 6, 7, and 8, and chart 2.) Although there was also at that time an increase in the disability discharge rates for neuropsychiatric disorders (table 3 and chart 1), it did not parallel the increase in neuropsychiatric admissions and admission rates. Large numbers of men who were below the minimum induction standards and for whom there were no suitable assignments available were discharged for the convenience of the Government (section X, AR 615–360).

But here too, abuses crept in. Many commanders used this opportunity to rid themselves of men whom for one reason or another they did not wish to retain. Such individuals were referred to dispensaries, clinics,

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enuresis.) But, even for the 1944–45 data, this differentiation seems to have been of questionable accuracy, showing a much lower proportion in the psychiatric category than has been observed in later experience. As is seen from the table, only 1,030 cases of enuresis were classified in 1944–45 under "Character and Behavior Disorders." However, additional 19,055 cases of enuresis were counted during the 1942–45 period under "General and Miscellaneous Diseases." Thus, altogether some 20,000 individuals were admitted to treatment facilities with a diagnosis of "enuresis," in World War II, indicating an annual admission rate of 0.8 per 1,000 mean strength per year.

[2] See chapter XVIII, "Neurology," table 60, for detailed diagnostic distribution.

[3] This diagnosis includes 250 admissions for "pathological personality," not elsewhere specifically classified.

NOTE.—Figures in parentheses are subtotals.

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[21] Uhler, C.: Perpetuation of Nervous Disorders by Army Psychiatric Procedure. J.A.M.A. 131: 652–656, 22 June 1946.

[22] Menninger, W. C.: Problems Confronting Psychiatry in the Army Convalescent Hospital. Am. J. Psychiat. 102: 732–734, May 1946.

and hospitals in the hope that medical officers would find some condition which placed the men below minimum induction standards. It appeared that many medical officers obligingly found disqualifying defects; commanding officers would then declare the men surplus and order them to separation centers for discharge. A survey at one separation center by representatives of the War Department revealed that a majority of the men sent to the separation center for discharge were not found to have disqualifying defects and a considerable number of these were labeled with psychiatric diagnoses.

The end of the war did not come in November. On 16 December 1944,

TABLE 7.—*Admissions for neuropsychiatric disorders, by broad diagnostic categories, month, and year, U.S. Army, worldwide, 1942–45*[1]

Month and year	Diagnostic categories				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1942					
January	4,598	956	3,642	475	3,167
February	4,641	1,008	3,633	476	3,157
March	5,877	1,262	4,615	673	3,942
April	6,248	1,237	5,011	703	4,308
May	6,981	1,381	5,600	718	4,882
June	8,189	1,536	6,653	820	5,833
July	9,498	1,830	7,668	902	6,766
August	10,802	2,101	8,701	968	7,733
September	11,895	2,287	9,608	1,142	8,466
October	13,544	2,616	10,928	1,309	9,619
November	14,470	2,894	11,576	1,400	10,176
December	17,312	3,351	13,961	1,724	12,237
Total	114,055	22,459	91,596	11,310	80,286
1943					
January	18,413	3,687	14,726	1,508	13,218
February	18,197	3,376	14,821	1,378	13,443
March	23,295	4,297	18,998	1,478	17,520
April	24,940	4,174	20,766	1,301	19,465
May	26,173	4,418	21,755	1,432	20,323
June	28,702	4,778	23,924	1,466	22,458
July	33,798	5,644	28,154	1,525	26,629
August	38,970	6,093	32,877	1,553	31,324
September	36,163	5,727	30,436	1,300	29,136
October	34,842	5,402	29,440	1,531	27,909
November	30,568	4,938	25,630	1,484	24,146
December	27,026	4,644	22,382	1,571	20,811
Total	341,087	57,178	283,909	17,527	266,382

See footnote at end of table, p. 219.

TABLE 7.—*Admissions for neuropsychiatric disorders, by broad diagnostic categories, month, and year, U.S. Army, worldwide, 1942–45*[1]—Continued

Month and year	Diagnostic categories				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1944					
January	27,030	4,315	22,715	1,825	20,890
February	24,695	4,230	20,465	1,790	18,675
March	25,305	4,455	20,850	1,935	18,915
April	22,960	3,840	19,120	1,975	17,145
May	27,830	4,165	23,665	2,255	21,410
June	27,170	4,010	23,160	2,050	21,110
July	33,150	4,095	29,055	1,920	27,135
August	31,165	4,010	27,155	1,535	25,620
September	37,010	4,365	32,645	1,570	31,075
October	37,595	4,650	32,945	1,765	31,180
November	37,775	4,115	33,660	1,595	32,065
December	36,130	4,295	31,835	1,685	30,150
Total	367,815	50,545	317,270	21,900	295,370
1945					
January	35,780	4,675	31,105	1,975	29,130
February	29,690	3,835	25,855	1,700	24,155
March	31,595	4,240	27,355	1,920	25,435
April	31,205	4,085	27,120	1,770	25,350
May	29,830	4,400	25,430	1,550	23,880
June	26,930	4,120	22,810	1,585	21,225
July	24,985	4,250	20,735	1,355	19,380
August	22,910	3,735	19,175	1,200	17,975
September	16,275	3,340	12,935	1,130	11,805
October	13,470	3,170	10,300	1,070	9,230
November	10,305	2,500	7,805	1,000	6,805
December	7,135	1,890	5,245	650	4,595
Total	280,110	44,240	235,870	16,905	218,965

[1] See footnote 1 to table 6.

the Germans started their offensive which resulted in the Battle of the Bulge, and again, there was a tightening of discharge policy. On 27 January 1945, the provisions of WD Circular No. 370, dealing with discharge policy, were rescinded.

Oversea Psychiatric Returnees

As already stated, in the latter part of 1944, when WD Circular No. 370 was still in effect, patients were being returned to the Zone of Interior

from overseas in large numbers (table 5).[23] There was a critical shortage of general hospital beds, and the convalescent hospitals were still unprepared to receive the very great load. A mechanism of discharging, for the convenience of the Government, had not yet been developed for psychiatric patients who were evacuated from overseas and who had recovered sufficiently to be returned to limited-duty assignments. By virtue of having had psychoneuroses, such patients were below the minimum induction standards, and there were very few available jobs to which they could be assigned. It was not known who could officially declare these men surplus. Authority for discharge from the service was not given to

TABLE 8.—*Admission rates for neuropsychiatric disorders, by broad diagnostic categories, month, and year, U.S. Army, worldwide, 1942–45*[1]

[Rates per 1,000 mean strength per year]

Month and year	Diagnostic categories				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1942					
January	30.6	6.4	24.2	3.2	21.0
February	30.3	6.6	23.7	3.1	20.6
March	31.0	6.7	24.3	3.6	20.7
April	30.4	6.0	24.4	3.4	21.0
May	30.4	6.0	24.4	3.1	21.3
June	33.8	6.3	27.5	3.4	24.1
July	35.6	6.9	28.7	3.4	25.3
August	37.0	7.2	29.8	3.3	26.5
September	38.2	7.4	30.8	3.7	27.1
October	37.8	7.3	30.5	3.7	26.8
November	36.6	7.3	29.3	3.5	25.8
December	38.6	7.5	31.1	3.9	27.2
1943					
January	37.9	7.6	30.3	3.1	27.2
February	39.2	7.3	31.9	3.0	28.9
March	42.4	7.8	34.6	2.7	31.9
April	45.5	7.6	37.9	2.4	35.5
May	44.9	7.6	37.4	2.5	34.9
June	50.0	8.3	41.6	2.6	39.0
July	55.2	9.2	46.0	2.5	43.5
August	63.5	9.9	53.6	2.5	51.1
September	60.6	9.6	51.0	2.2	48.8
October	56.5	8.8	47.7	2.5	45.2
November	50.9	8.2	42.7	2.5	40.2
December	43.3	7.4	35.9	2.5	33.3

See footnote at end of table, p. 221.

[23] In the Mediterranean theater, evacuation out of Fifth U.S. Army had been greatly reduced by improved organization of psychiatric combat services.—A. J. G.

TABLE 8.—*Admission rates for neuropsychiatric disorders, by broad diagnostic categories, month, and year, U.S. Army, worldwide, 1942–45*[1]—Continued

[Rates per 1,000 mean strength per year]

Month and year	Diagnostic categories				
	Total neuropsychiatric	Neurological	Psychiatric		
			Total	Psychosis	Other
1944					
January	43.0	6.9	36.1	2.9	33.2
February	41.6	7.1	34.5	3.0	31.5
March	39.8	7.0	32.8	3.1	29.7
April	36.5	6.1	30.4	3.1	27.3
May	42.0	6.3	35.7	3.4	32.3
June	42.1	6.2	35.9	3.2	32.7
July	49.1	6.1	43.0	2.8	40.2
August	46.3	6.0	40.3	2.3	38.0
September	56.4	6.7	49.7	2.4	47.3
October	56.2	7.0	49.2	2.6	46.6
November	57.9	6.3	51.6	2.4	49.2
December	54.0	6.4	47.6	2.5	45.1
1945					
January	54.3	7.1	47.2	3.0	44.2
February	45.1	5.8	39.3	2.6	36.7
March	47.2	6.3	40.8	2.9	37.9
April	46.5	6.1	40.4	2.6	37.8
May	43.5	6.4	37.1	2.3	34.8
June	40.1	6.1	34.0	2.4	31.6
July	37.3	6.4	30.9	2.0	28.9
August	34.6	5.7	28.9	1.8	27.1
September	25.3	5.2	20.1	1.8	18.3
October	22.9	5.4	17.5	1.8	15.7
November	21.4	5.2	16.2	2.1	14.1
December	19.1	5.1	14.0	1.7	12.3

[1] See footnote 1 to table 6.

the hospitals, and their only recourse was to send these men to duty. This involved sending such patients to a reception station where they were given 30 days' oversea leave. Following this leave, they were sent to a redistribution station where they generally remained for about 2 weeks, were then reexamined, and if no change was found were ordered to a station for duty. However, some of these men were returned to hospitals from the redistribution stations. Others were returned to hospitals after reaching their duty stations.

The attitude of most neuropsychiatric patients evacuated from overseas was that they had done their part. Almost all of them, without exception, wanted to get out of the Army. Very often, their psychiatric

symptoms were complicated by defective attitudes and feelings of resentment toward the Army. These feelings were intensified when they were returned to duty and resubjected to military discipline and basic training. They objected to being given combat instruction when they had just come from combat—and especially by officers, commissioned and noncommissioned, who had never experienced actual battle, as was often the case. To add to the difficulties, there were few assignments available in which they could do productive work. With histories of having been returned from overseas as patients, it was easy for commanding officers to explain all of such persons' difficulties in terms of illness and refer them to hospitals.

Conflict Within the Surgeon General's Office

A vicious circle was developed of hospital to duty to hospital. It was easier to discharge patients from the service than to correct the inherent defects in personnel, training, and assignment policies. Representatives of the Surgeon General's Office took it upon themselves, contrary to the advice of the professional consultants in the same office, to solve the problem for the War Department (and at the same time to make much needed hospital beds available for others who were returning from overseas) by personally encouraging hospital commanders and medical officers (during visits to hospitals) to discharge by CDD practically everyone who returned as a patient from overseas. It seemed to matter little that this action was directly contrary to expressed War Department policy.[24]

At the same time, representatives of the Neuropsychiatry Consultants Division continued to encourage medical officers to return to duty all those patients whom they felt were capable of doing duty. Their expressed policy and viewpoint was not to assume that a man was incapable of performing duty merely because he did not want to do duty. Hospital psychiatrists were confused by the conflict in verbal instructions they received from the professional consultants on the one hand and, on the other, from commanding officers of hospitals and other representatives of the Surgeon General's Office who were primarily concerned with making hospital beds available and avoiding public criticism.

An attempt was made to solve this problem in December 1944. A conference was arranged by General Menninger which was attended by representatives of other interested divisions of the Surgeon General's Office. The following considerations were presented by General Menninger:

1. The basic purpose of the Medical Department of the Army has always been to conserve manpower. In accordance with this, our principal objective should be to treat all those who need treatment and to return to duty as many men as possible.

2. The decision concerning a man's ability to do duty should not be based solely upon his ability to do full combat duty. Individuals vary considerably in their physical

[24] A personal opinion from the experience of the author who was on duty in the Surgeon General's Office at this time. No documentation is available.—A. J. G.

and mental (or emotional) capacities and it should be recognized that inability to perform combat duty over a long period of time does not necessarily imply illness. Stated in another way, those who are capable of performing limited service only are not necessarily sick. Extra demands placed upon an individual by combat service may produce symptoms of illness which disappear when an individual returns to activities which are more like those he has performed in civilian life. Therefore, the conclusion that those who had to be relieved from combat services are temporarily or permanently ill in a non-combat situation is not justified.

3. In determining whether or not a soldier is capable of performing duty, the Army as a whole and all its jobs should be considered. In general, an individual should not be discharged for disability when he is capable of performing limited service. The criteria or standards for disability discharges should remain consistent and fixed and only those who are actually disabled by disease or injury should be so discharged. This concept should not be confused by matters concerning compensation. Just because a soldier has incurred a condition or defect in the service and is therefore entitled to compensation, should not be adequate reason for his being discharged for disability. The Medical Department should be the only agency to determine who shall be discharged for disability. The criteria for such discharges should not be manipulated because of changing manpower needs.

4. The Medical Department should, therefore, be charged with the responsibility of returning to duty all those who are capable of doing duty. If there is no need for men with limited capacities at any given time, they should be released through administrative channels and perhaps return to a reserve status. It is conceivable that if the war were to last long enough, individuals with limited capacities might be required for full combat service, as apparently is now the case in the German Army. Discharging people for disability who are not really disabled, in addition to certifying them incorrectly as being incapable of performing any military service, is bad from a psychological standpoint. Many such individuals find it necessary to perpetuate their symptom upon return to civilian life in order to save face in their communities and to justify compensation, which they are not entitled to, on the basis of ill health. If the country feels indebted to such men for their military service, the compensation system should not be geared to the point where it is necessary for people to be invalids in order to obtain such compensation.

5. We are faced with the fact that the discharging of relative noneffectives had a bad effect on morale of those who remain in the service. Unfortunately, the present system of discharging has the effect of rewarding noneffectiveness. The use or abuse of medical channels to effect such discharges serves to aggravate the situation.

6. In relation to Paragraph I, it is the opinion of this office that any individual suffering from a psychoneurotic disorder, whether he be a Zone of the Interior or an overseas case, should receive treatment with the objective being to return to duty. When the Convalescent Hospital program was first developed, two considerations were paramount: 1.—That psychoneurotics did poorly in hospitals, where, because of lack of facilities and personnel, therapy could not be given, and, 2.—To make beds available in hospitals for those who were much more in need of hospital type care. The convalescent hospital then was to be a place where psychoneurotics could be treated, with the idea in mind that as many as possible would be returned to duty. It was on the basis of such an orientation that this office concurred in the plan which was proposed by the Hospital Division and Operations Service.

7. The opinion is expressed that no individual should be discharged from the service because of a psychoneurosis until he has been given the benefit of all the treatment we can give him in a Convalescent Hospital. Only those individuals who are too ill to be capable of performing limited service (and this should apply equally as well as to medical and surgical cases) should be CDD'd. In this connection, revision of MR 1–9 is indicated for the sake of consistency. If, for example, some psychoneu-

rotics are retained in the service for limited duty, then all psychoneurotics should not be rejected at induction.[25] The flow into the Army of men with defects which qualify them for limited service only can be regulated according to the demands for such personnel. Those who are not needed at any one time can be accepted for service but kept on a reserve status in civilian life.

8. The present system of using discharges via medical channels to control the size of the Army leads to the abuse of medical channels. It is generally known that medical officers have obligingly placed labels on individuals in order to cooperate with command in getting men out of the service. ASF Circular 318 directs that careful consideration should be given to whether or not an individual's defect is disabling to a degree that warrants discharge on a certificate of disability. Clear distinctions should be drawn between defects which do not preclude duty and those which are incapacitating for service. The presence of a defect does not necessarily constitute adequate cause for discharge on CDD. This principle has not been followed except with regard to some psychoneurotic patients.

9. We feel strongly that men who have recovered from wounds or illness and are still ineffective as a result of defective attitude, or because "they want to get out," should not be labeled as psychoneurotics or anything else in order to regulate the size of the Army. To discharge such individuals as sick, even under Section X, is a miscarriage of medical practice.

The difficulties, however, were not resolved, and the abuse of medical discharges continued. In one convalescent hospital where patients returned from overseas with mild psychiatric disorders were sent, 98 percent of all neuropsychiatric patients who were discharged from the hospital were discharged for disability. In another convalescent hospital with similar patients, only 10 percent of all neuropsychiatric patients were discharged for disability. The general hospitals which had been designated as psychiatric centers and which received the more seriously ill psychiatric patients (including all psychoses) were returning a much greater percent of patients to duty than some of the convalescent hospitals. It is quite likely that patients who were discharged for disability from some convalescent hospitals were less sick than many who were returned to duty from other hospitals. Maj. Herbert S. Gaskill, MC, of the Psychiatry Branch, Neuropsychiatry Consultants Division, in his report of 25 July 1945 of a visit to Madigan Convalescent Hospital to the chief of the Operations Service stated that about 10 percent of psychiatric patients arriving from debarkation hospitals required little or no treatment, having largely recovered by the time they reached the hospital.

Restatement of War Department Policy

On 28 September 1944, the Deputy Chief of Staff had sent a memorandum to the Assistant Chief of Staff, G–1, on the subject of psychoneurotics which initiated considerable interoffice correspondence and

[25] At about this time, perhaps as a result of this conference, a radiogram of 18 December 1944 was dispatched to all service commands (p. 171) which placed emphasis upon acceptance rather than upon rejection at induction stations. Further, it inveighed against indiscriminate discharge of limited-service personnel.—A. J. G.

resulted in a special survey of the problem. The correspondence and the survey are discussed fully on pages 102–108 and in appendix E.

The outcome of this correspondence and the subsequent investigation was WD Circular No. 81, dated 13 March 1945. This circular was drafted by representatives of the Surgeon General's Office, the Air Surgeon's Office, the Inspector General's Office, and the Office of the Assistant Chief of Staff, G–1, and read as follows:

1. Administrative disposition.—*a.* The purpose of this circular is to state War Department policy in regard to administrative and medical disposition of noneffective personnel. Medical channels for evacuation, reclassification, and discharge are designed for the disposition of individuals who are sick or injured. Noneffectives who are not disabled are to be disposed of by the command through nonmedical channels.

b. An enlisted man upon maximum benefit of medical treatment whose condition warrants medical discharge will be discharged under the provisions of AR 615–361. Those enlisted men who have demonstrated inadaptability to military service but whose psychiatric or physical condition is not such as to warrant disability discharge will be disposed of as directed by the approved proceedings of a board of officers convened under AR 615–368 or AR 615–369. In such cases the appropriate commander will convene promptly the board of officers required under the appropriate regulation. Only experienced qualified personnel will be appointed to such boards. Commanding officers will make available to these boards such administrative assistance as is necessary.

c. When an officer has demonstrated inadaptability to his assignment, and his psychiatric or physical condition is not such as to warrant placing him before an Army retiring board, prompt measures will be taken to initiate reassignment or reclassification under AR 605–230.

2. Medical disposition.—*a.* The diagnosis of any type of psychoneurosis implies sickness and disability of some duration. It is not to be applied for reasons of expediency in order to effect a disposition. It will be applied only when its use is justified by the existence of a clinical picture which satisfies the criteria for psychoneurosis as established by good medical practice. The mere presence of psychoneurotic symptoms which do not significantly impair the individual's efficiency or the presence of a predisposition to psychoneurosis does not warrant the diagnosis of any type of a psychoneurosis. Such individuals if otherwise sound will be considered as having no disease.

b. The various types of psychoneurosis such as anxiety state, conversion hysteria, etc., are sufficiently well defined to justify their use without being prefaced by the term "psychoneurosis." This term will therefore no longer be used on individual clinical records. Instead the particular type or types of psychoneurosis and the severity will be recorded as the diagnosis. In every case this will be followed by a statement of the degree and nature of the external stress which has precipitated the disorder and an estimate of the extent of the individual's predisposition.

c. The terms "operational fatigue" and "exhaustion" are acceptable as working diagnoses for psychiatric disorders incurred as a result of combat or other severe stress until a definitive diagnosis has been established.

d. The diagnosis of psychoneurosis of any type will not be entered on the WD AGO Form 38 or WD AGO Form 63 of any individual being separated from the service except under AR 615-361 unless the diagnosis has been established by a board of at least three medical officers, one of whom shall be a psychiatrist.

e. In determining disposition of cases, it must be clearly understood that there are many causes for noneffectiveness other than sickness. Among these are inaptness, inadaptability due to emotional instability, lack of physical stamina, misassignment,

defective attitude, and unwillingness to expend effort. Those who are ineffective by reason of any of these causes will be disposed of administratively.

f. There has been a tendency to attribute noneffectiveness to coexistent medical defects such as flat feet, lumbo-sacral strain, or mild psychoneurosis when actually these defects were not in themselves significantly disabling and the primary cause of the noneffectiveness was nonmedical, e.g., inaptness, inadaptability, defective attitudes * * *.

g. It should be clearly recognized that the presence of any type of psychoneurosis should not lead automatically to separation from the service. Many individuals with psychoneurosis recover or even if not fully recovered are capable of performing full duty. The disposition should depend solely upon the degree of incapacity after adequate treatment. In itself a mild psychoneurosis of any type will not be considered adequate cause for disability discharge. When an individual is suffering from a psychoneurosis which is not incapacitating he will be returned to duty.

h. When after careful medical evaluation, including psychiatric examination, it is the medical opinion that an individual has a condition which warrants consideration for discharge under provision of AR 615–368 or AR 615–369, and no condition is present which warrants discharge for disability, a certificate to this effect will be executed and forwarded by the psychiatrist to the individual's commanding officer, through medical channels. The certificate will include a statement specifying and describing the nonmedical condition in detail. Coexisting medical defects which do not warrant medical discharge will not be mentioned.

Abuse of Medical Discharge Continued

It was the first time that such a clear-cut expression of policy was made.[26] It was hoped that the problems of disposition of patients would be resolved. There followed some increase in the number of men returned to duty from hospitals, but abuses continued.

Commanders were reluctant to discharge men who had been overseas and in combat as inadaptable when they failed to conform to what was expected of them or in a passive way refused to do duty. There was the fear that the public and Congress would not understand how someone who had served honorably for several years and been in combat was being discharged as inadaptable.[27] Therefore, continued pressure was exerted on the Medical Department to dispose of them—and in many places, War Department policy continued to be flagrantly disregarded by medical officers who received support from those who were still primarily interested in the critical shortage of hospital beds.

"A full day's military duty"

The Surgeon General had thus far issued no written instructions concerning the conflicting views and pressures which resulted in confusion in the field. On 28 May 1945, he forwarded a letter entitled "Medical

[26] It is evident that General Menninger's views, as stated in pages 224–226, prevailed in the policy established by WD Circular No. 81.—A. J. G.

[27] This was an understandable reaction on the part of commanders. However, it illustrates the maltutilization of psychiatry and psychiatric diagnoses in dealing with problems of morale and motivation which, apparently, could not be realistically faced at that time.—A. J. G.

Clarification of Disposition Policy" to all service commands. It included the following instructions concerning disposition of patients:

> No patient should be returned to duty unless he can be expected to do an effective day's work in the military service. Many patients, especially those with prolonged hospitalization, reach maximum hospital improvement and leveling off but are unable to perform an effective day's duty. Patients in this group usually have not made the physical or psychological compensatory adjustments which are largely a function of time * * *. If a patient at the completion of his hospitalization has not reached a point where he can be expected to perform a normal day's effective work in the military service without probably readmission to the hospital system, he should be discharged on a Certificate of Disability Discharge.
>
> Illustrative of the type of patients to be discharged on Certificate of Disability are,
>
> (1) (Not applicable to NP Patients).
>
> (2) All patients with neuropsychiatric disorders who are not able to perform a full day's military duty.
>
> All patients with residual medical disabilities (reference to previous paragraph) should be discharged on Certificates of Disability Discharge.
>
> Individuals who have no residual medical disabilities but who are found inadaptable for further service by reason of psychopathic personality, adult maladjustment and mental deficiency should be disposed of under the provisions of AR 615–369 (honorable but nonmedical discharge) if their record of service warrants honorable discharge.
>
> To facilitate the discharge of the foregoing group of personnel, all hospital centers, general and convalescent hospitals should utilize appropriate boards * * *.
>
> Where individuals in the [above] group have rendered service which has been other than honorable, they will be returned to duty for administrative discharge and will not be separated from the service, while members of the detachment of patients.

Unfortunately, this letter did not clear up all the confusion. With regard to the psychiatric patients, there were divergent opinions on what to do with the very large group of patients who had been evacuated from overseas, who had mild residual neurotic disorders, but who were judged completely ineffectual because of their poor attitudes toward the Army and their expressed desire to be discharged from the Army. There was wide variation in the interpretation of the phrase "a full day's military duty." Many medical officers, cognizant of the unavailability of appropriate assignments in the Zone of Interior and realizing that men sent to duty often were put through basic training or given work which was just designed to keep them busy, were reluctant to recommend many men for duty. The number of CDD's continued to increase although it was generally recognized that a large proportion of the men being discharged for psychiatric disorders were at the time of discharge considered perfectly capable of doing a "full day's work" in civilian life.

It was the consensus of the service command neuropsychiatric consultants and of the Neuropsychiatry Consultants Division that, of the patients arriving at convalescent hospitals from overseas with psychiatric diagnosis, approximately 25 percent had no psychiatric disability which warranted hospitalization. Yet, only about 15 percent of all the psychiatric patients who were disposed of in all the Zone of Interior

convalescent hospitals during May and June of 1945 were returned to duty.

Further conflict within the Surgeon General's Office

To make matters worse and in direct conflict with existing War Department directives, The Surgeon General issued the following letter, on 11 September 1945:

> On the basis of detailed surveys recently completed of all convalescent hospitals, both by military and civilian consultants, the following clarification is offered concerning the disposition of patients:
>
> a. *Type of Disposition:* No patient should be returned to duty unless he is general duty.
>
> b. *Method of Discharge:* All patients with residual medical disabilities should be discharged on Certificates of Disability Discharge.
>
> c. Individuals who have no residual medical disabilities but who are considered inadaptable for further service should be disposed of under the provisions of AR 615–369, if their record of service warrants honorable discharge.

This, in effect, constituted an open invitation to CDD practically every patient who was evacuated from overseas since "general duty" implied "combat duty," and practically none of this group could be so classified because of some limitation—physical or psychological.

The "military and civilian consultants" referred to in the letter did not include any member of the Neuropsychiatry Consultants Division, nor any of the service command neuropsychiatric consultants, all of whom had on many occasions voiced opposition to such a policy.

The subject was brought up at a meeting of the War Department General Council on 5 November 1945.

On 23 November 1945, a representative of G–1 informed The Surgeon General that the matter of abuse of CDD's in convalescent hospitals had been discussed at the meeting of the General Council, and 6 days later, The Surgeon General's letter of 11 September 1945 was rescinded.

FINAL POLICY

It was not until 29 December 1945, 4 months after the war had ended, at a time when the matter had ceased to be important, that the final chapter was written. On that date, WD Circular No. 391 was issued, with the following instructions:

> 1. Enlisted personnel hospitalized in the United States will be disposed of in accordance with the provisions of this circular. Every effort will be exerted to return to duty all enlisted hospitalized personnel who can be expected to render effective military service of any type.
>
> 2. *a.* Enlisted personnel physically unfit for further effective service in the Army will be discharged in accordance with the provisions of AR 615–361 after maximum benefit from Army hospitalization has been obtained.
>
> *b.* Enlisted personnel physically fit for return to limited assignment or general

service duty (see WD Cir. No. 217, 1944, and WD Cir. No. 196, 1945) but who are eligible for separation from the Army under existing provisions of age, points, service, dependents, etc., will, as soon as maximum benefit from Army hospitalization has been obtained, be transferred on a duty status, direct from the hospital to the separation center, nearest his home.

c. Enlisted personnel physically fit to return to an appropriate duty assignment (general or limited service in accordance with the provisions of WD Cir. No. 217, 1944, and paragraph 4, WD Cir. No. 196, 1945) and who are not eligible for discharge under current directives will be disposed of as follows:

(1) Those likely to render effective service upon return to duty will be returned to an appropriate duty assignment.

(2) Those unlikely to render effective service upon return to duty by reason of likelihood of early recurrence of incapacitating symptoms as a result of continued military service, but who can be returned to civilian life without likelihood of such recurrence, will be transferred to the detachment of patients if not already so assigned, and ordered, on a duty status, to the separation center nearest their homes for discharge under the provisions of AR 615–365, and this circular. This procedure will not be utilized to discharge those individuals who should be discharged under the provisions of AR 615–368 or AR 615–369.

PSYCHIATRIC NOMENCLATURE

Psychiatric nomenclature which was barely adequate for civilian psychiatry was totally inadequate for military psychiatry. Use of the generic term "psychoneurosis" for all types and severity of neurotic disorders placed all individuals so labeled in a single category, the variations of which were never appreciated by line officers.[28] Unfortunately, the term "psychoneurosis" was often confused with the term "psychosis," and many individuals diagnosed as psychoneurosis were looked upon with suspicion of insanity by their associates and officers since both words contained the basic syllable "psycho" which is, and was, a commonly used lay colloquial term for designating a major mental disorder.

Adding to the difficulties of nomenclature were such blanket statements[29] as "there is no classification duty for patients with neuropsychiatric disorders" and "greater care will be taken * * * to prevent all individuals predisposed to or suffering from psychoneurosis * * * or having a proven history of such from entering the military service."

As stated previously, the criteria for the diagnosis of psychoneurosis were not uniform. The Inspector General found in a survey of many medical installations both in the Zone of Interior and overseas that the diagnosis of psychoneurosis was being abused by medical officers—that it was being applied to cases of transient situational maladjustments and of character and behavior disorders.

It appeared that, once a soldier was placed on limited duty or recommended for limited assignment because of an emotional disorder, it was unusual for him to ever revert to general service, because of the possibility

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[28] One could add: Also not understood or appreciated by medical officers, including psychiatrists.—A. J. G.

[29] See footnote 12, p. 201.

of a recurrence of his difficulty. A prevalent misconception was that psychoneurotic disorders would develop in all such predisposed individuals whenever they were exposed to any stressful situation.

Psychoneurosis became practically a household word, and there was hardly a soldier who was unfamiliar with the word "psycho." To differentiate between cases of chronic psychoneurotic disorders and those which developed as a result of the stress of operational or combat flying, to minimize the stigma of a psychiatric diagnosis, and to emphasize the situational aspects and lack of permanence of the disorder, the Air Forces adopted the terms "operational fatigue" and "flying fatigue" for those cases of psychoneurosis which resulted from the stress of hazardous or combat flying. This concept was quickly and widely adopted by Ground and Service Forces combat units where the term "exhaustion" and later "combat exhaustion" and "combat fatigue" were used for those emotional disturbances which resulted from the stress of combat.[30]

The use of these terms was remindful of the term "shell shock" which became the wastebasket for neuropsychiatric diagnosis in World War I. Before long, the terms "operational fatigue," "flying fatigue," "combat exhaustion," and "combat fatigue" were applied to cases other than those which were combat incurred. In many instances, it was applied to men who had never been in combat and even to men who had never left the continental limits of the United States. Other difficulties encountered were: According to an official ruling, Air Forces personnel hospitalized for "flying fatigue" could receive flight pay, while hospitalized, similar to personnel with physical injuries or disease. However, if the diagnosis was psychoneurosis, they were not eligible to receive flight pay—on the assumption that it was not the result of an injury or disease.

To effect some standardization in the use of such terms and to dispel the existing confusion, The Surgeon General issued the following directive in October 1943:[31]

> In certain theaters it has been found that the term "psychoneurosis" produced in the patient's mind the idea of war causation and incurability and thus materially interfered with recovery. The term "exhaustion," on the other hand, implied to the patient nonspecific etiology, natural occurrence, and speedy recovery. It was also in a measure true, in that in the majority of cases this exhaustion was a strong contributory factor. If it is found expedient to use the term "exhaustion" as a preliminary diagnosis for combat neuropsychiatric casualties, the term should be employed only on the emergency medical tag and the case rediagnosed with the proper diagnostic term on the field medical record. The use of the term "exhaustion" for psychoneurosis will be confined to cases developing under enemy action. Cases of exhaustion free from

[30] The term "exhaustion" was first used in a II Corps directive issued in April 1943 to designate combat psychiatric casualties. Later, NATOUSA (North African Theater of Operations, U.S. Army) directives continued to direct the use of this diagnosis. In the same sense, the Marine Corps utilized "fatigue" and "combat fatigue" for the psychiatric casualties of the Guadalcanal fighting. A full discussion of the origin of the term "exhaustion" is contained in "Medical Department, United States Army. Neuropsychiatry in World War II. Volume II. Oversea Theaters" [in preparation].—A. J. G.

[31] Circular Letter No. 176, Office of the Surgeon General, U.S. Army, 20 Oct. 1943.

psychiatric components and essentially "physical in nature" will be qualified with an appropriate term in addition to the word "exhaustion," for purposes of differentiation.

Change of psychiatric nomenclature.—In September 1944, the Deputy Chief of Staff requested the Assistant Chief of Staff, G–1, to study the entire problem of psychoneurosis (p. 102) for the purpose of "determining what improvements could be made in Army procedures and publicity in the handling of psychoneurotics." He stated:

A competent authority has expressed the fear that in their enthusiasm the psychiatrists within the Army are overdoing their diagnosis of psychoneurosis and are overdoing the publicity on this subject. If the War Department builds up a clinical record and a diagnosis that a soldier is a psychoneurotic it will probably impair the individual's future civilian usefulness and may greatly increase the number of men dependent upon Government disability allowance. In many of these cases the individual became a psychoneurotic because he was unable to adjust himself to his position in the Army. Many of these individuals will have no difficulty in returning to their former civilian environment and will be normal in every respect in continuing a way of life to which they were accustomed and adjusted prior to their induction in the Army. If they are labeled as psychoneurotics their former employers will be reluctant to take them and the individual concerned will become convinced that he cannot readjust himself to his previous civilian environment. It is understood that the Navy is now diagnosing these cases as "No disease. Temperamentally unqualified for Naval service." It is suggested that the Army may well use a similar diagnosis.

Shortly afterward, the Air Surgeon requested The Surgeon General to call a conference for the purpose of standardizing nomenclature and defining terms which were then in use.

In connection with the request of the Deputy Chief of Staff for a report on the problem of psychoneurosis, The Surgeon General made the following comments in a comprehensive report to G–1:

It has been suggested that the word psychoneurosis be changed to something else that is less imposing and frightening. This office has consistently maintained that the word is an accepted medical term with a specific meaning and that if a new word were substituted, it would soon carry with it all the associations of the present one. Any stigma which is attached to the diagnosis would carry over to any other word used in its place. Cancer or syphilis called by any other name would still be the same. The difficulty is not with the term but rather with the attitude toward and understanding of the term. Furthermore, much of this existing confusion and misunderstanding can be traced to the fact that psychoneurosis was called "shell shock" in the last war. To introduce still another misnomer at this juncture could not but lead to even further misunderstanding. The solution is believed to be in education rather than evasion of the term.[32]

On 25 January 1945, The Surgeon General called a conference which was attended by the civilian consultants in neuropsychiatry to the Secretary of War and by representatives of the Veterans' Administration, the

[32] In retrospect, the repeated defense of the term "psychoneurosis" by the psychiatrists in the Surgeon General's Office was an error as demonstrated later by the successful effort of Menninger *et al.* (p. 232) in introducing a new psychiatric nomenclature in which two new categories, the "transient personality reactions" and the "immaturity reactions," made unnecessary the wholesale usage of the term "psychoneurosis." These new categories have now been used successfully for years, including the Korean War period.—A. J. G.

Air Surgeon's Office, the Bureau of Medicine and Surgery of the U.S. Navy, the U.S. Public Health Service, and the Surgeon General's Office. It was the consensus of the conferees that, whenever possible, a psychiatric diagnosis should include four parts:

1. The type of disturbance or disorder.
2. The external precipitating stress which caused the disorder.
3. The extent of the predisposition.
4. The degree of impairment of functional capacity resulting from the disorder.

It was also agreed that the term "psychoneurosis" should be regarded as an inclusive term which could be omitted from the more specific diagnoses, such as anxiety reaction or conversion reaction.

These recommendations were included in The Surgeon General's memorandum to G–1 on the subject of psychoneurosis and were later adopted by the War Department[33] and appropriate instructions issued to the field (see "Medical Disposition," *a*, *b*, and *c*, p. 225).

The method of recording the diagnosis of psychoneurosis was elaborated upon in a later publication[34] which outlined the criteria to be used in describing the severity of stress, the degree of predisposition, and the amount of incapacity.

War Department Technical Bulletin (TB MED) 203.—The final step in the modernization of psychiatric nomenclature was taken when a markedly revised list of standard diagnoses was published in TB MED 203 and issued on 19 October 1945. The new nomenclature was the work of General Menninger over a period of 14 months. He personally solicited the opinions and recommendations of over 100 of the outstanding psychiatrists in the country and made numerous revisions until the final draft was accomplished. The dynamics of psychopathology was chosen as the basis for the classification of the psychoneuroses.

A new group was added—the transient personality reactions to acute or special stress. It included such disorders as combat exhaustion and acute situational maladjustment. The term "psychopathic personality" was eliminated and replaced by "character and behavior disorders" which were subdivided into: (1) Pathological personality types, (2) addiction, and (3) immaturity reactions. The term "somatization reaction" was also introduced. It included all of the so-called "organ neuroses."

All of the needed changes were thereby brought about. No longer did the diagnosis of psychoneurosis appear with annoying frequency. The four-part diagnosis permitted individualization and, in effect, represented a brief description of the case. A more dynamic system was substituted, and some of the undesirable categories were eliminated.

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[33] War Department Circular No. 81, 13 Mar. 1945.

[34] War Department Circular No. 179, 16 June 1945.

LINE-OF-DUTY DETERMINATION OF NEUROPSYCHIATRIC DISORDERS

Initial Criteria

Because of the chronic nature of most neuropsychiatric disorders, peacetime criteria for LD (line-of-duty) determination were continued during the early days of the war. They were based on the knowledge that "in many chronic diseases and degenerative conditions, symptoms appear only after many months or even years, and that in such conditions incapacitating defects may arise as a natural consequence of the disease and not as the logical incident or probable effect of duty in the service." [35]

All cases of dementia praecox, manic depressive psychoses and psychoses of a similar nature, and psychoneurosis developing within 6 months after entry into active military service were to be regarded as having existed prior to service. Cases developing after 6 months' active duty were to be regarded as having been incurred in line of duty "* * * when a careful review of the past history fails to elicit evidence of mental abnormality or functional nervous disorder before the original entrance into active military service or during the first six months of such service." [36] It was permissible to use medical judgment in making the LD determination.

Revision

In May 1944, to conform with Veterans Regulations No. 1 and to facilitate the adjudication of claims for pensions, the criteria for determining line of duty were revised. The new criteria were based on the assumption that, lacking evidence to the contrary, a disease or injury was service connected and, therefore, in line of duty—unless it resulted from misconduct or neglect, or occurred while absent without official permission or out of activities not connected with the service.

The Veterans Regulations provided:

> Every person employed in the active military or naval service shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of enrollment or where clear and unmistakable evidence demonstrates that the injury or disease existed prior to * * * enrollment and was not aggravated by such active military or naval service.[37]

Under this regulation, length of service per se was no longer to be a decisive factor. The important considerations were (1) what was written down in the findings of the induction physical examination and (2) clear and unmistakable evidence concerning the disease or disorder.

All cases of psychosis and psychoneurosis were, therefore, to be con-

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[35] Army Regulations No. 40–1025, Changes No. 1, 21 Aug. 1942.

[36] *Ibid.*

[37] Veterans Regulations No. 1 (a), pt. 1, par. 1 (b), as amended by Public Law No. 144, 78th Cong.

sidered "in line of duty" except where there was clear and unmistakable evidence that the disorder existed prior to entry into the service and that it was not permanently aggravated by service.

When these guides were incorporated in AR 40–1025, 12 December 1944, upon the recommendation of the Neuropsychiatry Consultants Division, the following addition was included with reference to neuropsychiatric disorders:

> Whenever "permanency" of aggravation must be established, as in determination of eligibility for retirement benefits, an aggravation (of a psychiatric disorder) will not be considered permanent if it is purely situational and if it is evident that it will be removed, with reversion of the disorder to its previous degree of severity, within a reasonable time upon return to civilian life.

Defects of revision.—While in many induction stations, great care was exercised in performing and recording the results of the medical histories and examinations, there were other stations where, because of the large volume of work and shortage of medical officers, the psychiatric portion of induction physicals was performed in a perfunctory fashion. For example, in one induction station, it was necessary to process 600 men each day and, with just 1 psychiatrist, approximately 30 seconds were devoted to the neuropsychiatric portion of the examination. Here, thorough and intensive study of each man was not possible, neuropsychiatrically or any other way. (This was in contrast to other induction stations located in metropolitan areas where availability of psychiatrists permitted much more careful evaluation.) Therefore, to assume that complete and careful examinations could be performed on every man entering the service during wartime was unrealistic.

In many instances where men related histories of epilepsy, nervousness, headaches, and weakness, but were unable to supply "proof" that these conditions existed before acceptance into the service and no objective evidence of these conditions were apparent on examination, the men were inducted often without notation being made on their induction records. When these men were later discharged and applied for pensions, there was no clear and unmistakable evidence (if the individual chose to change his story) to prove that the condition existed prior to induction, and nothing to contradict a claim of aggravation.

The effect of a law (Veterans Regulations) which placed the responsibility on the Government for any illness which occurred in military personnel during wartime was (1) to increase the rate of rejections and (2) to cause the Government to pay pensions to men whose conditions existed before entry into the service and were not truly aggravated by service.

A great deal of publicity had been given to the cost of caring for the many neuropsychiatric casualties of World War I, and those psychiatrists who were impressed with the figures undoubtedly rejected many men who were borderline cases, but who might well have made good adjust-

ments in the Army, in order to avoid the possibility of their becoming responsibilities of the Government. They did this in compliance with directives which were written with those same considerations in mind.

A trial period of duty with administrative discharge for preexisting defects which are discovered during that time would have had the effect of allaying the fears of examining psychiatrists and would have decreased the number of rejections at induction. Further, by such a trial period, the Government would have been spared the responsibility for illnesses which were not truly service connected.[38]

SPECIAL PROBLEMS

Enuresis

The problem of bed wetting has bothered armies for time immemorial. Bed wetting subjects the individual to the taunts of the others, results in some loss of sleep, introduces the complication of increased linen and bedding requirements if malodorous situations are to be avoided, increases the possibility of exposure to cold or inclement weather when in bivouac, and makes for difficult situations under crowded housing conditions, such as on troop transports.

Traditionally, the Army attitude toward nocturnal enuresis (which was not the result of organic disease) was that of an "undesirable habit" and handled such cases in several ways. One method was to turn the individual over to a proverbial tough sergeant who by such techniques as having the man awakened every hour throughout the night or pitiless ridicule was supposed to cure him. This, however, was by no means the usual manner of dealing with cases of nocturnal enuresis.

Another method was developed at Camp Abbot, Oreg., where the post commander, in September 1943, established an enuresis tent near the post stockade under the supervision of the provost marshal for all military personnel suffering from enuresis, cause undetermined.[39] Its purpose was for "training in self-regulation and self-discipline." Company commanders upon learning of repeated bed wetting of any member of their commands were required to report the individual to the post inspector who, if the facts so warranted, would refer the individual to the provost marshal. The individual continued in training with his organization but was not permitted to drink "cokes," beer, or soft drinks at any time, was permitted coffee only for breakfast, and received no pass or furlough privileges except in cases of emergency. He was delivered to the provost marshal one-half hour after the evening mess call and was permitted no fluids from supper to reveille. He was awakened every 2 hours during the night and

[38] This describes the common Navy philosophy and practice of administrative separation of noneffective trainees during the initial training phase (boot camp).—A. J. G.

[39] Administrative Memorandum No. 25, Camp Abbot, Oreg., 16 Sept. 1943.

taken to the latrine. Or, discharge for undesirable habits might be recommended and separation from the service effected with either "blue" (without honor) or "white" (honorable) discharge, depending upon the individual commander's discretion.

As time went on, the attitudes toward and the management of enuresis became more medically and psychiatrically oriented. Thorough medical workup was given in most posts to exclude the possibility of organic genitourinary or nervous system disease. In some stations, medical discharges were given even when no organic disease was found.

Policy and procedures for dealing with enuresis were not uniform until 1 January 1944 when section VIII, AR 615–360, was modified by changes No. 18, as follows:

> It is now a generally accepted medical and psychiatric opinion that enuresis is not necessarily a habit, but rather may be a symptom of some underlying mental or physical condition. Underlying causes of enuresis may be organic disease, psychoneurosis, psychosis, mental deficiency, psychopathic personality or lack of proper juvenile training.
>
> Generally, if the case is studied completely, one of the above diagnoses will be established. Therefore, in each case a complete mental and physical evaluation of the person afflicted will be done by qualified medical officers and a decision made as to disposition. If the individual is to be discharged, decision will be made as to the appropriate section of these regulations to be utilized. The type of discharge should also be decided solely on the merits of each individual case and governed by the nature of the determined underlying cause rather than by the resultant enuresis.

When the conduct of an enlisted man was such as to render his retention in the service desirable except for his enuresis, an honorable discharge was to be given. Relatively few cases of enuresis were found to be due to physical or mental disease; a majority were considered to be due to "lack of proper juvenile training"—but the practice of penalizing this unhappy group with "blue" discharges was discontinued.

No differentiation was made before 1944 between enuresis as a habit reaction—symptomatic of immaturity—and enuresis as a symptom of some organic disorder(s). Therefore, no data for admissions for enuresis (in its psychiatric connotation) are shown in table 6, dealing with neuropsychiatric admissions in World War II, for the period before 1944. However, if all types of enuresis were taken into account, some 20,000 persons were admitted with such a diagnosis during World War II, indicating an admission rate of 8 per 10,000 mean strength per year.[40]

Homosexuality

There was a similar evolution in the disposition of homosexuals. Initially, all cases of homosexuality who were not tried by courts-martial (where offenses were involved) were given "blue" discharges. A man on his own initiative or because of noticeable difficulty in adjusting might

[40] For further details, see footnote 1 to table 6, p. 216.

visit or be sent to a psychiatrist for consultation. When it was ascertained that the basis of the maladjustment was homosexuality and this was reported to the individual's commanding officer, the subject usually received a "blue" discharge. Objections to this harsh practice were raised by many homosexuals whose attempts to receive help from a medical officer resulted in their being discharged "without honor." Further, confidence in medical officers was undermined by the Army requirement that these officers report even those confidential statements given in a professional consultation. The homosexual was being singled out as a result of irrational prejudices, even though he was no more responsible for his aberration than the mental defective was responsible for his central nervous system pathology. World War II data indicate that some 5,500 persons were admitted to hospitals with a diagnosis of "pathological sexuality," primarily "homosexuality."[41]

Col. Roy D. Halloran, MC,[42] who was chief of the Neuropsychiatry Consultants Division in the early part of the war, while feeling that the problem of homosexuality had not created serious difficulties, attributed some progress in the handling of the problem to the publication of WD Circular No. 3, issued on 3 January 1944. This directive permitted the giving of a "blue" discharge to an offender who was not deemed reclaimable, in lieu of court-martial, and provided for hospitalization of those who were deemed reclaimable. Included in the reclaimable category were those who were guilty of first offenses, those who acted as a result of intoxication or curiosity, or "those who acted under undue influence, especially when such influence was exercised by a person of greater years or superior grade."

The commanding officer of the hospital at which such an individual was hospitalized was required to transmit to The Adjutant General (and to theater headquarters, if overseas) a full report of the diagnosis, treatment, results of treatment, and recommendation as to disposition, to be kept on file. Depending upon the results of treatment, the individual was returned to duty or separated from the service or tried by court-martial, this decision being made by higher authority. If returned to duty, the reclaimed offender was then assigned to a different organization so that he could start anew.

Actually, there was little in the way of individual intensive treatment that could be given to such men in a military setting.[43] Adequate evaluation was possible, however. It is not known just how many homosexual offenders were salvaged for further duty under this system, but probably less than 1,000. The fact that any were salvaged is significant.

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[41] In regard to statistical data on homosexuality, one can agree with Menninger that such data "are probably of little if any importance as an indication of either the true incidence or significance of the problem * * *. Probably for every homosexual who was referred or came to the Medical Department, there were 5 or 10 who never were detected." (Menninger, William C.: Psychiatry in a Troubled World. New York: The Macmillan Co., 1948, pp. 226-227.)—A. J. G.

[42] Halloran, R. D.: Problems of Neuropsychiatry in United States Army. M. Ann. District of Columbia 13: 17–23, January 1944.

[43] In all fairness, it should be recognized that few homosexuals were or are given individual intensive psychiatric treatment in civil life.—A. J. G.

Neither Army regulations nor WD Circular No. 3 specified the method of disposition of a homosexual who was not guilty of any offense. It was common practice, however, to give "discharge without honor" (blue) to any individual discharged because of homosexuality, on the premise that homosexuality constituted an undesirable trait of character.

To correct this practice, the Surgeon General's Office recommended a change in Army regulations[44] to indicate that only those homosexuals who were guilty of sexual misconduct in the service should be considered for "blue" discharges. Further, that those who were not guilty of any sexual offense and who had a satisfactory record of service should be given an honorable discharge. Concurrence in this, however, could not be obtained from other War Department agencies because it was feared that many adjusted homosexuals would seek to be discharged and that others might claim to be homosexual for the purpose of being separated from the Army with honorable discharges.

Without prior knowledge of the Surgeon General's Office, a change to AR 615–368 was issued about a month later to the effect that "the mere confession by an individual to a psychiatrist that he possesses homosexual tendencies will not in itself constitute sufficient cause for discharge * * *."[45] Provision was made for hospitalization upon the recommendation of the psychiatrist for the purpose of determining if the individual should be restored to duty or separated from the service. The implication was that if separated it would be with a "blue" discharge.

After a series of conferences with representatives of the major forces of the Army, a memorandum was forwarded in July 1945 by The Surgeon General to the Assistant Chief of Staff, G–1, expressing the opinion that "personnel who were inadaptable for service by reason of homosexuality were entitled to honorable discharges providing they were guilty of no offense and their service had been honorable and faithful." It was pointed out that when an individual voluntarily sought medical assistance and this resulted in a "blue" discharge, faith in medical officers was lost, and in effect, such an individual was given the same consideration as one who had committed homosexual offenses and whose services had not been satisfactory. It was suggested that a person with homosexual tendencies was no more responsible for his condition than was one with mental deficiency. Men in the latter category were given honorable discharges when released because of inaptness.

This memorandum resulted in the preparation of a confidential letter, in the Adjutant General's Office, on the disposition of homosexuals. This letter, dated 31 October 1945, was addressed to all commanding officers

[44] Army Regulations No. 615–368, 7 Mar. 1945. (Section VIII, AR 615–360, was replaced by AR 615–368—Undesirable Habits or Traits of Character, Enlisted Men, Discharge, dated 20 July 1944; and AR 615–369—Enlisted Men, Discharge—Inaptness, Lack of Required Degree of Adaptability or Enuresis, dated 20 July 1944.)

[45] Army Regulations 615–368, Changes No. 1, 10 Apr. 1945.

having general court-martial jurisdiction.[46] From the psychiatric standpoint, it represented great progress in the solution of this highly charged problem. It provided for honorable discharges (under the provisions of AR 615–369) of enlisted personnel who were released because of lack of adaptability resulting from homosexual tendencies, and who had committed no sexual offenses while in the service. It did not imply that all confessed homosexuals should be discharged merely on the basis of a confession of homosexuality. Officers who were found to be inadaptable for service as a result of homosexual tendencies were permitted to resign for the good of the service. A report of medical examination, including psychiatric examination, was required to be forwarded with the letter of resignation. Where no sexual offense had been committed and where record of service justified an honorable discharge, upon review, the qualification "for the good of the service" would be disregarded and resignation under honorable conditions accepted.[47]

Malingering

The subject of malingering [48] comes to the foreground in every war—but perhaps less in this war than others because of greater understanding of the dynamics of human behavior.[49] Certain line officers and tough first sergeants would from time to time insist that most individuals with functional disorders were fakers or cowards and initially handle them accordingly. Many others may have had similar opinions but did not translate their thoughts into words or actions. Never during the war did there develop a witch hunt for malingerers. There are no reliable medical statistics available on the frequency of malingering since it was not included as a medical diagnosis. Where an individual was suspected of malingering, a diagnosis of "No Disease" was usually entered on the clinical record. It was then left to that person's commanding officer to prefer charges, if he so desired. If charges were preferred, the ultimate decision concerning the existence of malingering was resolved by court-martial.

The following figures on the number of cases tried for malingering (excluding self-inflicted wounds) and the number found guilty during the war were obtained from the Office of the Judge Advocate General:

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[46] This came out on 23 March 1946 as WD Circular No. 85.

[47] The achievement of a more enlightened management of the homosexual problem during the end phase of World War II was rapidly lost in the postwar years. A revision of AR 615–368, issued on 14 May 1947, deleted any reference to or procedure for reclaiming homosexual offenders and made it increasingly difficult to obtain an honorable-type discharge for the confessed homosexual who had committed no offense in the service. However, the last chapter on Army policy for dealing with homosexuality (AR 635–89, 8 Sept. 1958) provided that self-confessed homosexuals or other homosexuals with no provable offense in the service (so-called Class III) were required to be given an honorable-type discharge.— A. J. G.

[48] This subject (with others in this chapter) is comprehensively reviewed by William C. Menninger, *in* Psychiatry in a Troubled World. New York: The Macmillan Co., 1948.

[49] See footnote 42, p. 237.

	Number of cases	
	Tried	Guilty
July 1941–July 1942	3	2
July 1942–July 1943	5	3
July 1943–July 1944	10	8
July 1944–July 1945	28	25
July 1945–December 1945	1	1

It was, however, the consensus of medical officers that exaggeration of existing disorders and not malingering—for the purpose of avoiding duty—was not uncommon. This practice, however, was by no means confined to those with neuropsychiatric disorders. Patients with arthritis or sinusitis were as apt to demonstrate this common trait as were those with psychoneurosis. The psychopath with an established pattern of deceitful

TABLE 9.—*Percent distribution of admissions for neuropsychiatric disorders and psychiatric disorders, by diagnosis, U.S. Army, 1942–45* [1]

Diagnosis	Percent		
	Total (worldwide)	Continental United States	Oversea theaters
	Neuropsychiatric Disorders		
Neurological disorders:			
Epilepsy	1.6	2.1	0.9
Other	14.2	13.7	14.9
Total	15.8	15.8	15.8
Psychiatric disorders:			
Psychosis	6.1	5.6	7.0
Psychoneurosis	58.8	57.5	60.8
Character and behavior disorders:			
Pathological sexuality	0.5	0.6	0.4
Asocial and antisocial personality types	.2	.3	.2
Immaturity reactions	6.1	7.3	3.9
Alcoholism	3.9	3.7	4.1
Drug addiction	.1	.2	.1
Enuresis	[1] NA	[1] NA	[1] NA
Total	10.8	12.1	8.7
Disorders of intelligence	2.6	3.6	1.1
Other psychiatric disorders	5.9	5.4	6.6
Total psychiatric disorders	84.2	84.2	84.2
Total neuropsychiatric disorders	100.0	100.0	100.0

See footnote at end of table, p. 241.

TABLE 9.—*Percent distribution of admissions for neuropsychiatric disorders and psychiatric disorders, by diagnosis, U.S. Army, 1942–45* [1]—Continued

Diagnosis	Percent		
	Total (worldwide)	Continental United States	Oversea theaters
	Psychiatric Disorders		
Psychiatric disorders:			
Psychosis	7.3	6.6	8.3
Psychoneurosis	69.8	68.4	72.2
Character and behavior disorders:			
Pathological sexuality	0.6	0.7	0.5
Asocial and antisocial personality types	.3	.3	.3
Immaturity reaction	7.3	8.7	4.7
Alcoholism	4.5	4.4	4.8
Drug addiction	.1	.2	.1
Enuresis	[1] NA	[1] NA	[1] NA
Total	12.8	14.3	10.4
Disorders of intelligence	3.1	4.3	1.3
Other psychiatric disorders	7.0	6.4	7.8
Total psychiatric disorders	100.0	100.0	100.0

[1] See footnote 1 to table 6. "NA" signifies "Not Available."

behavior was perhaps the one in whom simulation or true malingering was most consistently found. In combat, cases of suspected self-inflicted wounds and simulated amnesias were seen. It was extremely difficult, however, to definitely prove malingering.

The subject came up for discussion in relation to the prevention of psychiatric disorders. It was reported by the Inspector General, following the survey of the subject of psychoneurosis in the European theater in the spring of 1945, that "the combined expression of many combat experienced line officers reflects their belief that stronger disciplinary action against malingerers, deserters and individuals proved to be suffering from self-inflicted wounds would greatly decrease the number of psychiatric casualties." It was therefore recommended to the Deputy Chief of Staff that disciplinary examples should be made and sentences enforced in proved cases. The Surgeon General who concurred in this view was requested to prepare the appropriate directive, subsequently issued on 29 September 1945 as WD Circular No. 298. In preparing the directive, great care was taken to point out the difficulties involved in positively establishing a diag-

nosis of malingering so that injustice would not be done to those with psychoneuroses who were often looked upon with suspicion by uninformed line officers. Unfortunately, this much needed clarification appeared after the war had ended, and its effect was never determined.

FREQUENCY OF NEUROPSYCHIATRIC DISORDERS

There were somewhat over 1,103,000 admissions with a diagnosis of a neuropsychiatric disorder in World War II. Somewhat over 174,400 admissions were for neurological disorders, and 929,000 admissions for psychiatric disorders (table 6).

Neurological Disorders

The World War II admissions for neurological disorders constituted 15.8 percent of all admissions for neuropsychiatric disorders. These percentages were the same for continental United States and for overseas (table 9). The World War II admission rate for neurological disorders was 6.9 per 1,000 mean strength per year. By year, the highest admission rate (8.3) occurred in 1943 (table 6); by month, the highest rate was in August 1943—9.9 per 1,000 mean strength per year (table 7 and chart 2).[50]

Psychiatric Disorders

Admissions for psychiatric disorders constituted 84.2 percent of all World War II admissions for neuropsychiatric disorders. Among the specific psychiatric disorders, psychoneurosis was the most prominent.

Psychoneurosis

There were some 648,500 admissions in World War II with a diagnosis of psychoneurosis. This diagnosis constituted 58.8 percent of all admissions for neuropsychiatric disorders, or 69.8 percent of the psychiatric disorders (table 9). This admission rate for psychoneurosis for the entire World War II period was 25.6 per 1,000 mean strength per year. As just indicated, this rate fluctuated widely; it rose from a yearly rate of 16.7 in 1942 to a yearly rate of 29.9 in 1944. (See tables 6 and 8 and chart 2; the diagnostic category marked "other" is mainly psychoneurosis.)

By far, the most common types of psychoneurosis in World War II were the anxiety reactions. Somatization reactions were extremely common with psychogenic gastrointestinal disorders[51] heading the list in this

[50] For a detailed analysis of the neurological disorders by specific diagnoses, see chapter XVIII, "Neurology."

[51] Halstead, J. A.: Gastrointestinal Disorders of Psychogenic Origin; Management in Forward Areas. Bull. U.S. Army M. Dept. 9: (suppl.) 163–180, 1949; and The Management of Soldier's Stomach Among Combat Infantrymen; Evaluation of Psychiatric and Physical Factors. J. Nerv. & Ment. Dis. 105: 116–123, 1945.

category and psychogenic cardiovascular reactions being next most frequent. In one survey, 66 percent of an unselected series of psychoneuroses in general hospitals in the Zone of Interior showed some psychogenic somatic disturbances of clinical importance. In 27 percent of the cases, the organic dysfunction was the primary and chief difficulty.

Major conversion reactions manifested by paralyses, convulsions, deafness, blindness, and the like were considered to be much less common than they were in World War I—and were most apt to occur in individuals with limited or defective intelligence.

Predisposition versus stress.—The vast majority of men who were hospitalized for psychoneurosis after a brief period of service were individuals who brought their psychoneurosis with them into the Army.[52] They were induction errors for the most part. Sometimes, the physician was honestly mistaken because of ignorance or lack of insight, but sometimes he was under pressure to accept defective men against his better judgment. Sometimes, the physician's judgment was reversed with or without his knowledge. Only a small proportion would have required hospitalization in civilian life.[53] Symptoms were often temporarily aggravated by the relatively mild stress incidental to induction and training but frequently subsided upon admission to the hospital or with promise of discharge. Unfortunately, some of these individuals as a result of their brief exposure to military service may never again reach the same levels of effectiveness that they maintained before entering the Army. They have been supplied with facesaving, socially acceptable, and sympathy-producing explanations for their difficulties and compensation to maintain a dependent attitude.

Those who broke down in combat and especially after prolonged combat were, for the most part, previously well adjusted persons with no histories of overt psychiatric disorder. Upon careful investigation, however, it was found that there were latent personality and emotional difficulties in many of these men for long periods of time.[54] In the combat-incurred group, anxiety reactions were again by far the most common, but evidences of depression were apparent in a relatively large portion of these and of the entire group of combat neuroses.

Psychosis

Of all admissions for neuropsychiatric disorders in World War II, psy-

[52] A typical broad utilization of the term "psychoneurosis" in World War II, when perhaps "neurotic predisposition" or "neurotic personality" was intended.—A. J. G.

[53] See footnote 4, p. 196.

[54] It should be noted, however, that similar histories of emotional difficulties could be obtained from combat wounded and successful combat soldiers and that such past or latent difficulties may have no significant relevance to combat psychiatric disorders. *See* Ludwig, A. O., and Ranson, S. W.: A Statistical Followup of Effectiveness of Treatment of Combat-Induced Psychiatric Casualties; I.—Returns to Full Combat Duty; II.—Evacuation to the Bases. Mil. Surgeon 100: 51–62, January 1947; 169–175, February 1947.—A. J. G.

chotic disorders constituted 6.1 percent (table 9). Some 67,600 patients were admitted to hospitals and were diagnosed as psychotics, constituting 7.3 percent of the psychiatric admissions. The overall World War II admission rate for psychoses was 2.7 per 1,000 mean strength per year, without showing much fluctuation either by year or by month (tables 6 and 8 and chart 2).

As in World War I, the development of acute transient schizophrenic reactions was not uncommon. These constituted approximately 5 to 15 percent of all the psychoses.[55] Most of them occurred in combat situations,[56] but some were seen in the base areas and even in the Zone of Interior. During the acute phase, they could not be differentiated cross sectionally from the chronic psychotic reactions except, perhaps, for the extreme confusion and disorientation which they showed so consistently. In general,

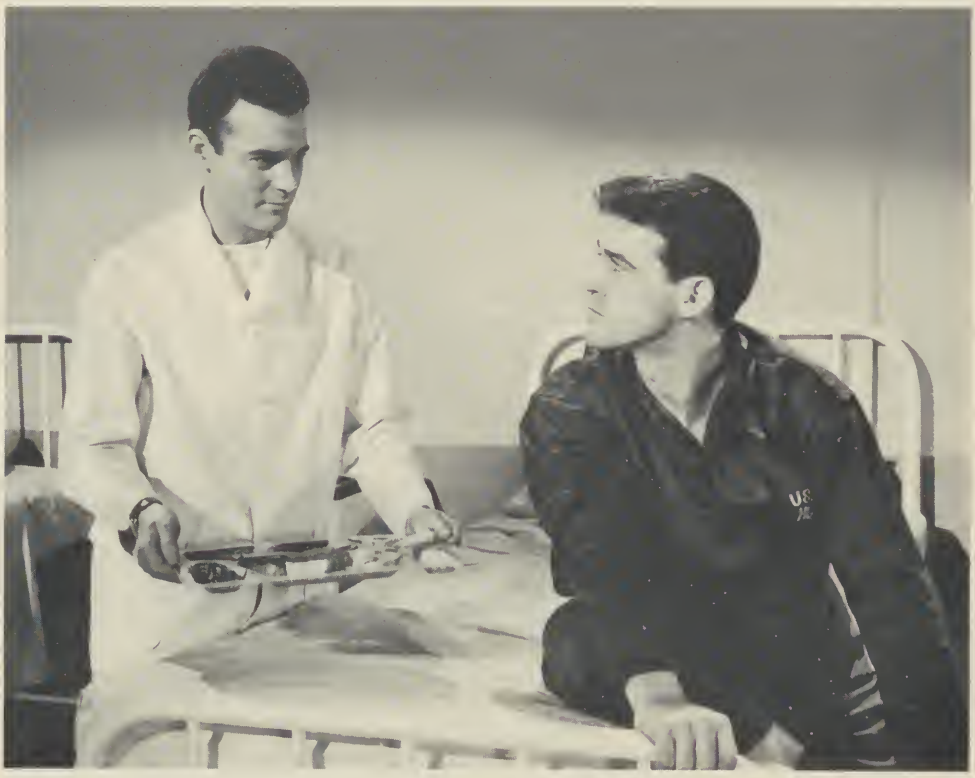

FIGURE 27.—A neuropsychiatric attendant bringing a tray of food to a mental patient in a paranoid state. Patient believes the food to be poisoned. [Posed by professional actors.]

[55] This is the author's own impression; there are no statistical data available.—A. J. G.

[56] In combat, such reactions were diagnosed as "pseudopsychotic" and were not considered to be schizophrenic. A full discussion of this subject is contained in "Medical Department, United States Army. Neuropsychiatry in World War II. Volume II. Oversea Theaters." [In preparation.]—A. J. G.

FIGURE 28.—A disturbed patient in a seclusion room. [From the film "Shades of Gray."]

schizophrenic reactions were many times more common than were effective disorders and, not too uncommonly, were seen superimposed on mental deficiency or psychopathic personality (figs. 27 and 28).

As the war progressed and with the increased emphasis upon therapy, the proportion of patients with psychoses who required further hospitalization, upon discharge from the service, steadily diminished. With the introduction of shock treatment and with a comprehensive activities program, only 20 to 30 percent of all those who were hospitalized for psychoses had to be transferred to Veterans' Administration hospitals. The remainder either recovered or were sufficiently improved to be released to their own custody or to the custody of relatives.

Character and behavior disorders, and other disorders [57]

Among the character and behavior disorders, immaturity reaction counted for the greatest number of admissions; it constituted 6.1 percent of all admissions for neuropsychiatric disorders, or 7.3 percent of the psychiatric admissions (table 9). Next to follow are: Alcoholism (3.9 percent of all neuropsychiatric admissions, or 4.5 percent of the psychiatric admissions); pathological sexuality (0.5 percent of all neuropsychiatric admis-

[57] This diagnostic category includes enuresis discussed as a special problem on pages 235–236.

sions, or 0.6 percent of the psychiatric admissions); asocial and antisocial personality (0.2 percent of all neuropsychiatric admissions, or 0.3 percent of the psychiatric admissions); and drug addiction (0.1 percent of the neuropsychiatric admissions and 0.1 percent of the psychiatric admissions).

Some 29,000 admissions in World War II were diagnosed as disorders of intelligence. They constituted 2.6 percent of all neuropsychiatric admissions, or 3.1 percent of the psychiatric admissions.

Factors affecting psychiatric admission and discharge administrative policies.—As already described, both admissions and discharges were affected to a very considerable extent by changes in administrative policies involving the utilization of manpower.[58] These policies fostered the use of nonmedical criteria as the basis for defining medical disability caused by neuropsychiatric conditions. For this reason, these fluctuations cannot be considered as evidence of changes in actual incidence of psychiatric disorders even though they were reported as such statistically. For example, the decline in admission rates beginning in November 1943 resulted from WD Circular No. 293 (11 November 1943) and from WD Circular No. 164 (26 April 1944; amended by WD Circular No. 212, 29 May 1944). The discharge of any individual who could render effective service was prohibited except those who were permanently below the minimal physical standards of MR 1–9 as a result of combat wounds. Since it was a common practice for marginal personnel to be hospitalized for the purpose of discharge from the service, such directives strongly influenced admission rates. Thus, the low rate of admissions obtained as a result of these directives was continued until September 1944 when the admissions again rose rapidly as a result of WD Circular No. 370 (issued on 12 September 1944 and modified by ASF Circular No. 318, issued on 23 September 1944) which authorized the discharge of enlisted men in the United States who did not meet minimum physical induction standards for limited service as prescribed by MR 1–9 and for whom there were no appropriate positions reasonably available.

Carded-for-record cases.—Another factor which resulted in an increased admission rate throughout 1944 was the frequent practice of the Army Air Forces to admit, as carded-for-record cases (credited as admissions), large numbers of men passing through the redistribution stations. A very significant number of these cases were never hospitalized but were merely afforded the opportunity of a 30-day sick leave before returning for duty. Annual admission rates resulting from the procedure at various redistribution stations ranged as high as 1,600 per 1,000 strength. These rates were higher than those of divisions in combat.

Outpatient treatment.—The admission rates do not constitute a complete expression of the magnitude of the neuropsychiatric problem in the Zone of Interior because a significant number of men with neuropsychiatric

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[58] The following War Department directives and Army Regulations affected admissions and discharges: WD Circular No. 161, 14 July 1943; WD Circular No. 176, 31 July 1943; WD Circular No. 293, 11 Nov. 1943, rescinded WD Circular No. 161; WD Circular No. 164, 26 Apr. 1944; WD Circular No. 217, 1 June 1944; AR 615–369, 20 July 1944; and WD Circular No. 370, 12 Sept. 1944.

conditions were treated in outpatient status without admission to hospitals. There was an increasing tendency for this practice throughout 1944 and 1945. In addition, with the establishment of mental hygiene consultation clinics in all training centers, many other neuropsychiatric cases were spared hospitalization and were successfully treated on an outpatient status. No statistics are available to indicate the extent of the neuropsychiatric outpatient caseload, but at large camps, it can be stated as a reasonable estimate that the number of consultations equaled or exceeded the number of neuropsychiatric hospital admissions.

Undiagnosed psychiatric manifestations.—A questionnaire study by the Information and Education Division, Army Service Forces, of 5,000 enlisted men returned to the Zone of Interior from overseas indicated a high incidence of potential or undiagnosed psychiatric or mental health problems. The questionnaire included the key questions from the NSA

CHART 3.—*Neuropsychiatric patients remaining in hospital: total and by open and closed wards, continental United States, 1943–45*

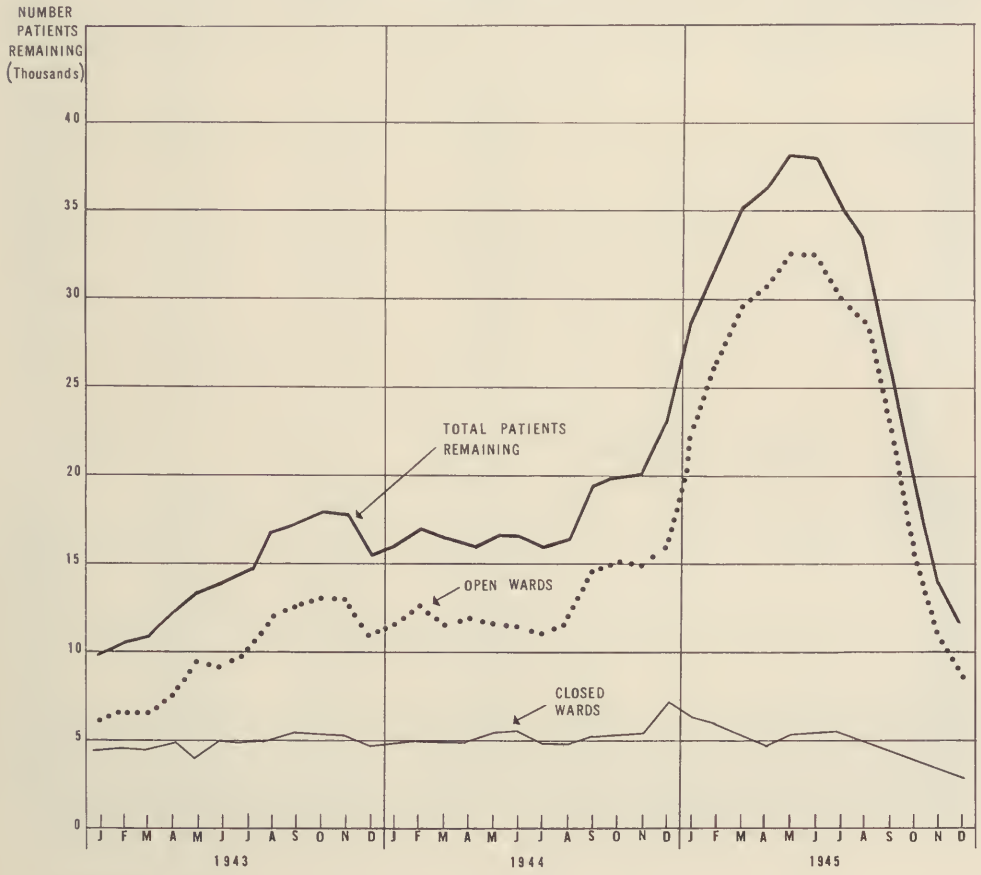

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TABLE 10.—*Neuropsychiatric patients remaining in hospital: number and percent of all remaining hospital patients, by year, month, and percent distribution by closed and open wards, U.S. Army, continental United States, 1943–45*

Year and month	Neuropsychiatric patients remaining in hospital		Percent distribution by—	
	Number	Percent of all remaining hospital patients	Closed wards	Open wards
1943				
January	9,716	6.0	42.8	57.2
February	10,366	5.8	41.5	58.5
March	10,633	6.0	42.1	57.9
April	12,035	6.5	39.6	60.4
May	13,014	7.4	30.5	69.5
June	13,606	7.9	35.8	64.2
July	14,488	7.9	33.4	66.6
August	16,817	9.0	29.6	70.4
September	17,123	8.7	29.8	70.2
October	17,818	9.2	28.5	71.5
November	17,606	9.1	28.6	71.4
December	15,191	8.7	29.8	70.2
1944				
January	15,974	8.7	29.0	71.0
February	16,826	9.5	28.2	71.8
March	16,035	10.1	30.9	69.1
April	15,582	10.3	30.3	69.7
May	16,162	10.8	31.1	68.9
June	16,444	11.5	32.4	67.6
July	15,793	10.9	30.9	69.1
August	16,157	10.9	30.2	69.8
September	19,346	11.9	26.0	74.0
October	19,924	11.8	26.0	74.0
November	19,940	11.7	26.4	73.6
December	22,906	13.0	31.1	68.9
1945				
January	28,199	12.5	22.9	77.1
February	31,485	13.0	18.3	81.7
March	34,333	12.9	15.0	85.0
April	35,696	12.7	13.7	86.3
May	37,640	12.6	14.1	85.9
June	37,541	11.8	14.2	85.8
July	34,928	11.1	15.3	84.7
August	32,974	11.0	14.7	85.3
September	26,700	10.0	16.3	83.7
October	19,542	8.5	19.4	80.6
November	13,947	7.0	22.4	77.6
December	11,384	6.8	25.3	74.7

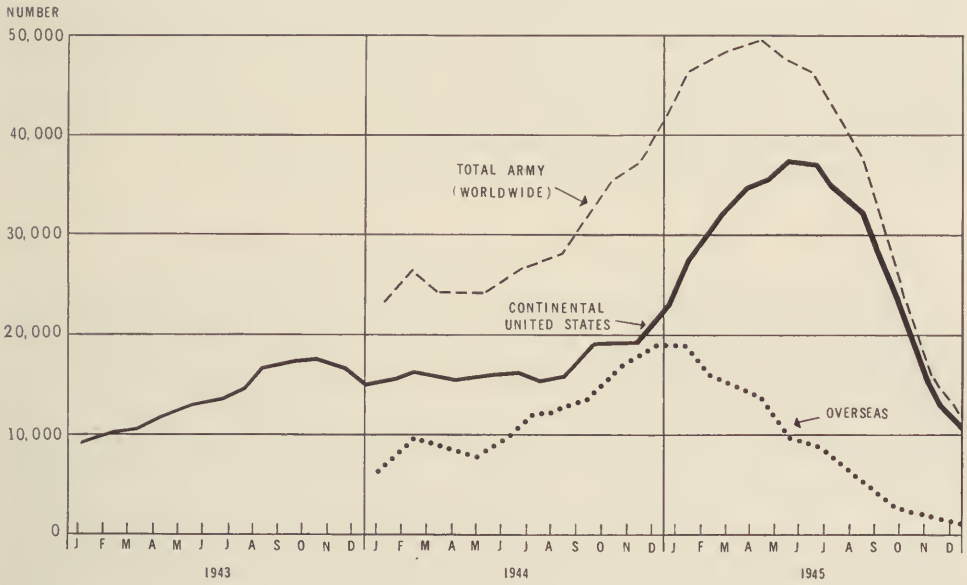
(Neuropsychiatric Screening Adjunct) test which was used at induction.[59] This study revealed that from 52 to 73 percent of the returnees answered positively as to their having many "somatic" and "nervous symptoms." While it is not to be thought that all or even most of these men had psychiatric illness of any degree, yet it is highly probable that they represented a more than average potential source of psychiatric noneffectives.

Another survey based on the NSA was made in the Pacific Ocean Areas. The results were even more startling than those of the aforementioned study, for "only 7 percent of all the veterans and only 6 percent of the infantry veterans stated that they were in good physical condition. In other words they felt that they were in 'ill health' and, therefore, not fit for combat." [60] It was believed that these findings could be related to the presence of many psychosomatic manifestations of anxiety or psychoneurotic difficulties.

Prevalence of Neuropsychiatric Disorders in Hospitals

The prevalence of neuropsychiatric disorders in hospitals is measured here by the number of psychiatric patients remaining in hospitals at the

CHART 4.—*Number of neuropsychiatric patients remaining in hospitals, 1943–45 (as of end of month)*



[59] The NSA, a standarized series of questions relative to physical and mental health, was established on 1 October 1944 "to provide a means of rapidly selecting those registrants having indications of psychoneurotic tendencies and who, therefore, require an additional clinical neuropsychiatric examination." (WD Memorandum No. 40–44, 19 Sept. 1944, "Psychological Examining for Neuropsychiatric Tendencies.") See also pp. 185–188.—A. J. G.

[60] Kaufman, M. R.: Ill Health as an Expression of Anxiety in a Combat Unit. Psychosomatic Med. 9: 104–109, March–April 1947.

end of each month. These data are presented in table 10, by month, covering the period from January 1943 through December 1945. This table also shows the proportion of such patients as a percent of all patients remaining in hospital and their percent distribution by closed and open wards. See also chart 3 for the distribution of all neuropsychiatric patients, and separately by closed and open wards.

The prevalence depends, of course, on the number of admissions—it parallels, therefore, to a great extent the trend of admissions as depicted in chart 2, and on the length of hospitalization. It is apparent from table 10 and chart 3 that the number of neuropsychiatric patients remaining in hospitals increased in the latter month of 1944, reaching its peak in May 1945. With this increase in the number of neuropsychiatric patients, the proportion of these patients in open wards also progressively increased. The increase in both instances was due to: (1) The greater number of patients being evacuated from overseas as a result of an increase in combat activity—increasing, thus, the admission rates in continental United States, and (2) the policy of the Surgeon General's Office which throughout 1944 placed greater emphasis on the treatment of neuropsychiatric patients, especially of those falling in the psychoneurosis category.

The utilization of convalescent hospital facilities as treatment centers for patients with psychoneurosis, who did not require individual therapy, afforded an opportunity for retaining patients for treatment for 6 to 8 weeks. Patients receiving treatment under this program constituted an increasingly higher proportion of the neuropsychiatric patients remaining in hospitals. About 45 percent of the total number of neuropsychiatric patients were treated under the convalescent program. (See chart 4 for the distribution of the neuropsychiatric patients remaining in hospitals, for continental United States and overseas, by month.)

Discharges for Neuropsychiatric Reasons

Of the specific diagnoses responsible for the disability discharges of neuropsychiatric disorders in World War II, psychoneurosis was the most prevalent cause of discharge (table 2). Of the total number of persons (389,000) discharged from the Army for neuropsychiatric disorders, some 269,000 persons were discharged for psychoneurosis; in other words, 69.1 percent of all neuropsychiatric disability discharges were due to psychoneurosis. Next in magnitude were the discharges for psychosis (62,000 persons), constituting some 15.9 percent of all disability discharges for neuropsychiatric reasons, followed by discharges for neurological reasons (some 52,000 persons, or 13.4 percent). The remaining discharges were due to character and behavior disorders (0.8 percent), disorders of intelligence (0.7 percent), and other psychiatric reasons (0.1 percent). The same percentage distribution by diagnosis obtained for enlisted men (table 2).

During the period of mobilization, the vast majority of neuropsychi-

atric disorders for which discharge was recommended was clearly in existence prior to service. An analysis of 200 consecutive case histories of soldiers discharged from the Army,[61] at Camp Lee, Va., because of neuropsychiatric disabilities revealed that in 89 percent the illness had existed in civilian life (in over 50 percent for more than 5 years). Of the 11 percent in which onset had seemingly occurred after induction, all but one patient were psychotic. Almost half were admitted to the hospital within the first month of service and 97 percent within 6 months after induction.

Ebaugh[62] found that neuropsychiatric discharges constituted 26.5 percent of all discharges from a typical station hospital during the period of 1 December 1942 to 1 June 1943.

Kinsey[63] studied 1,000 consecutive unselected cases that were medically discharged from the Army in the latter part of 1942 and early part of 1943 (when any psychoneurotic disorder was cause for discharge). Of the discharges, 53.5 percent were for neuropsychiatric disorders.

The most common diagnosis was found to be psychoneurosis, as indicated by the overall World War II data (table 2). (See also appendix A for a comparative evaluation of World War I and World War II discharges for disability.)

TABLE 11.—*Administrative separations of enlisted men for inaptitude or unsuitability, unfitness, reasons other than honorable (excluding unfitness), and dishonorable discharges, and total specified administrative separations, numbers and rates, by year, 1942–45*

[Rate expressed as number of separations per 1,000 mean strength per year]

Year	Inaptitude or unsuitability [1]		Unfitness [2]		Reasons other than honorable [3]		Dishonorable discharges		Total specified administrative separations	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1942	3,486	1.2	2,153	0.7	2,285	0.8	933	0.3	8,857	2.9
1943	40,165	6.5	14,262	2.3	3,421	.6	3,321	.5	61,169	9.9
1944	41,184	5.8	16,049	2.3	3,653	.5	7,577	1.1	68,463	9.7
1945	37,629	5.7	8,191	1.2	2,915	.4	8,623	1.3	57,358	8.7
Total	122,464	5.4	40,655	1.8	12,274	0.5	20,454	0.9	195,847	8.6

[1] Includes enlisted men discharged under section VIII, AR 615–360, prior to July 1944; under AR 615–369 and changes, after July 1944.

[2] Includes enlisted men discharged under section VIII, AR 615–360, prior to July 1944; under AR 615–368 and changes, after July 1944.

[3] Includes discharges for misconduct and bad conduct (excluding unfitness).

Source: The following sources were used in the preparation of these data: Adjutant General's Reports: ETM–54c and 59c—for the earlier years, and "Strength of the Army" STM–30, Adjutant General's Office, Machine Records Branch—afterward. In each case, the latest available statistics were used. (See also appendix A, table 9.)

[61] Rosenberg, S. J., and Lambert R. H.: Analysis of Certain Factors in the Histories of 200 Soldiers Discharged From the Army for Neuropsychiatric Disabilities. Am. J. Psychiat. 99: 164–167, September 1942.

[62] Ebaugh, Franklin G.: History of the Eighth Service Command. [Official record.]

[63] Kinsey, R. E.: Study of 1,000 Cases Separated From the Army on Certificate of Disability Discharge. Bull. U.S. Army M. Dept. 69: 64–75, October 1943.

Administrative Discharges for Enlisted Men

In addition to military personnel discharged for neuropsychiatric reasons on CDD, some 196,000 enlisted men were administratively separated from the service in World War II for various noneffective behavioral disorders. These administrative separations consisted of 122,000 enlisted men

TABLE 12.—*Administrative separations for inaptitude or unsuitability, unfitness, reasons other than honorable (excluding unfitness), and dishonorable discharges, by year and month, 1942–45* [1]

Month	Year							
	1942	1943	1944	1945	1942	1943	1944	1945
	Inaptitude or Unsuitability				Unfitness			
January	125	1,193	3,886	2,382	77	353	1,620	969
February	124	1,612	3,390	2,176	98	483	1,576	867
March	136	2,591	3,563	2,319	134	653	1,435	743
April	176	2,344	3,177	2,281	144	779	1,326	679
May	214	2,279	3,391	2,055	127	875	1,284	577
June	233	3,235	3,994	3,564	136	1,251	1,645	894
July	284	3,370	2,153	4,094	210	1,456	847	869
August	262	3,672	3,606	5,561	191	1,532	1,385	698
September	276	4,566	4,200	3,700	203	1,774	1,210	494
October	431	5,723	3,624	4,903	227	1,896	1,248	596
November	464	5,264	3,276	2,844	287	1,466	1,238	490
December	761	4,316	2,924	1,750	319	1,744	1,235	315
Total	3,486	40,165	41,184	37,629	2,153	14,262	16,049	8,191
	Reasons Other Than Honorable				Dishonorable Discharges			
January	185	125	55	240	55	90	644	715
February	187	239	201	228	60	136	683	632
March	259	223	169	169	83	165	617	632
April	219	410	106	190	76	223	551	778
May	204	314	174	155	69	223	560	709
June	230	273	172	355	77	286	699	1,150
July	195	265	441	127	85	323	495	619
August	196	185	388	234	81	323	682	627
September	144	268	469	181	73	384	646	625
October	174	385	524	382	84	428	682	664
November	157	417	330	301	93	354	603	789
December	135	317	624	353	97	386	715	683
Total	2,285	3,421	3,653	2,915	933	3,321	7,577	8,623

[1] See footnotes to table 11.

separated for inaptitude or unsuitability (including enuresis); 41,000, separated for unfitness; 12,000, for reasons other than honorable, including misconduct and bad conduct; and 20,000, dishonorably discharged (table 11). Inaptitude or unsuitability were the main cause of administrative separations (62.5 percent of these separations); unfitness constituted 20.8 percent; discharges for reasons other than honorable, 6.3 percent; and dishonorable discharges, 10.4 percent.

Altogether these administrative separations in World War II showed a discharge rate of 8.6 per 1,000 mean strength per year. As in the case of the disability discharges, the administrative separations indicate wide variations year by year, and month by month, due primarily to changing administrative policies, especially with respect to inaptitude or unsuitability and unfitness (tables 11 and 12).

WORLD WAR II MEAN STRENGTHS

The mean Army strengths in World War II, 1942–45, are shown in table 13. These strengths were used in computing the rates shown in the various tables in this chapter.

TABLE 13.—*Mean Army strengths, total Army and enlisted men, by year, 1942–45*

Year	Mean strengths		Year	Mean strengths	
	Total Army personnel	Enlisted men		Total Army personnel	Enlisted men
1942	3,242,710	3,015,620	1944	7,791,006	6,982,533
1943	6,870,616	6,256,936	1945	7,432,042	6,512,699

CHAPTER X

Station and Regional Hospitals

Norman Q. Brill, M.D.

ORGANIZATION AND FUNCTIONS

In the station hospitals which were established in the many camps, posts, and stations in the Zone of Interior, psychiatry and neurology was generally a section of the medical service. Actually, in most hospitals with sizable neuropsychiatric programs, the section operated quite independently under its own chief, without the intimate professional supervision which the chief of the medical service gave to other sections of that service.

In some instances, neuropsychiatry did not have even the status of a section (for example, Camp Roberts Station Hospital, Calif.).[1] In such situations, patients with psychiatric disorders were intermixed on the wards of the medical and surgical services except for disturbed psychotic patients who were housed in a closed ward under the supervision of a psychiatrist.

Ordinarily, the neuropsychiatric section was responsible for the admission, treatment, and disposition of all patients with psychiatric and neurologic disorders. In addition, it provided psychiatric and neurological consultations to the rest of the hospital. The number of consultations at times were very great and constituted a responsibility that equaled in importance the operation of the wards. Some hospitals developed formal psychiatric outpatient clinics to which units on the post might refer personnel for consultation—and in which inpatient consultations might be seen. Psychiatric consultations for dependents were usually arranged on an individual basis and, generally, were not considered an integral part of the program.

Menninger[2] commented on the magnitude of the psychiatric consultation load. He pointed out how a man in civilian life might fail to function effectively with no serious concern to anyone in contrast to the situation in the military:

> Unless he becomes a worry to his family or the law, his inefficiency or incapacity may receive no attention. This point is of greater contrasting significance when one recognizes the major adjustment demands which the Army requires of any individual joining it, with his complete loss of free choice about what he does, when and how he

[1] Letter, Lt. Col. Malcolm J. Farrell, MC, to The Surgeon General (through Chief, Professional Services), Washington, D.C., 13 Mar. 1944, subject: Report of Visit of Lt. Col. Malcolm J. Farrell, MC, to Ninth Service Command Installations.

[2] Menninger, W. C.: Development of Psychiatry in the Army in World War II. War Med. 8: 229–234, October 1945.

does it. Since the tendency in our culture is to retreat into illness when under stress, it is not surprising to find many individuals finding enormous secondary gain by becoming ill in the Army, thus hoping to escape the demands of duty and service.

Unfortunately, the majority of civilian psychiatric patients have to be brought to the psychiatrist by relatives, usually after a long period of "putting up" with the patient. In the Army, they are "discovered" more quickly; the officer, the sergeant, the bunkmate, the dispensary surgeon, the aid station surgeon, the flight surgeon, the internist, or the surgeon may refer a man to the psychiatrist.

Where closed-type prison wards existed, they were generally adjacent to the closed-type psychiatric wards and often, in the early part of the war, were under the administrative direction of the chief of neuropsychiatry. In rare instances, prisoners would be admitted to the closed psychiatric ward itself. This was specifically prohibited by later directives.

At the Station Hospital, Fort McPherson, Ga.,[3] and probably at other posts near large cities, the psychiatrists assigned to the neuropsychiatric section were detailed for much of their time to the induction station. While the mental hygiene clinics which were developed in the various training centers were ordinarily under the commanding officer of the training center, in several posts (for example, Station Hospital, Camp Kohler, Calif.), the training center mental hygiene clinic was under the commanding officer of the station hospital and was operated by the chief of the neuropsychiatric section.[4] It was found that hospital admissions were significantly reduced when there were well-functioning outpatient or mental hygiene clinics.

In one hospital (Station Hospital, Fort Dix, N.J.) in 1942, in accordance with a standing order of the post, all alcoholic addicts were admitted to the hospital, and psychiatric examinations were made on all prisoners in the guardhouse.

While examination of military personnel confined in the guardhouse or undergoing trial by court-martial was not done routinely, there were many occasions where psychiatric examination, and at times testimony, was sought from the station hospital psychiatrists. Where mental hygiene clinics existed in training centers, the psychiatrist in that unit provided such service to the training center.

Psychiatric examination was required when board proceedings were undertaken to discharge enlisted personnel for lack of adaptability, inaptitude, enuresis, or undesirable habits and traits of character, including homosexuality. Before rendering such a report, some psychiatrists admitted the person in question to the neuropsychiatric section of the hospital for observation and examination. In other instances, the subject would be examined on outpatient status.

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[3] Memorandum, Lt. Col. Malcolm J. Farrell, MC. for The Surgeon General (through: The Director, Medical Practice Division), Washington, D.C., 18 Feb. 1943, subject: Neuropsychiatric Inspection of Lawson General Hospital, Ga., 28 January 1943; Station Hospital, Fort McPherson, Ga., 29 January 1943; School of Military Neuropsychiatry, Lawson General Hospital, Ga., 27, 28, 29 January 1943; Station Hospital, Fort McClellan, Ala., 30 January 1943; Induction Station, Fort McClellan, 30 January 1943; and the Infantry Replacement Training Center, Fort McClellan, 30 January 1943, by Lt. Col. Malcolm J. Farrell, MC.

[4] See footnote 1, p. 255.

PHYSICAL FACILITIES

The neuropsychiatric section in the typical cantonment-type station hospital was located in the rear left corner of the hospital. There were closed wards for disturbed psychoses and also for those potentially suicidal depressions and acting out psychopathic disorders which could not be safely housed on open wards. Open wards adjacent to closed wards were for patients with mild psychotic, psychoneurotic, personality, and neurological disorders (including epilepsy).

Closed Wards

The typical closed wards (fig. 29), designated W–8 on the 1920 quartermaster plans which were used for building these hospitals, had a 23-patient capacity and contained 7 single rooms, a 4-bed room, and a ward for 12 patients. A small dayroom was located in the center of the ward. It served as a dining room during mealtime. There was a porch off the dayroom and another off the large ward.

As originally constructed, these wards were very insecure. Patients could break out of the ward through windows and doors almost at will. At some hospitals, the entire closed-ward section and, in others, the individual closed wards were surrounded by a high wire fence with barbed wire often mounted on top of it. It was possible to get the barbed wire removed in some hospitals, but in others, the commanding officers insisted on its retention. The deficiencies of the W–8 wards eventually came to the attention of the Office of the Chief of Engineers in the War Department, and directives were issued which made possible alteration of the wards so that reasonable security was afforded.[5]

There were continuous tubs in a few hospitals, but not in most, and no facilities for occupational therapy were included in the original plans. Recreation and play areas were generally limited to the small space between adjacent wards.

The lack of adequate facilities in closed wards was probably related to the expectation that psychotic patients would be disposed of promptly and not be retained for treatment. This expectation, as will be discussed later, proved to be erroneous. Individual chiefs of sections and their staffs used considerable ingenuity in arranging for additional recreational space and for establishing occupational therapy and gardening areas adjacent to the closed-ward section. The aid of the Red Cross was enlisted in providing arts and crafts and activities on the wards.

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[5] Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior, United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956, chs. II and V.

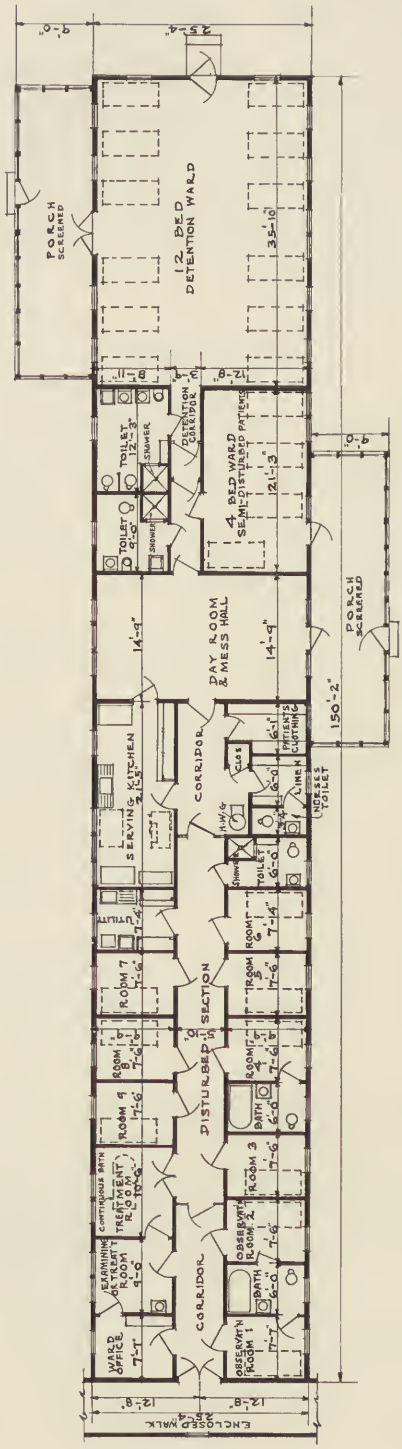

FIGURE 29.—Floor plan of a typical neuropsychiatric ward.

Open Wards

The deficiency in closed-ward facilities for disturbed patients was paralleled in some hospitals by the opposite disadvantage of using closed wards for open-ward cases. Apparently, planning of the psychiatric sections of the cantonment-type hospital had been concerned primarily with

TABLE 14.—*Admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, continental United States, 1942–45* [1]

[Rate expressed as number of admissions per 1,000 mean strength per year]

Diagnosis	Total 1942–45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Neurological disorders: [2]										
Epilepsy	14,147	1.0	3,757	1.4	5,655	1.1	3,015	0.8	1,720	0.6
Other	93,095	6.2	14,820	5.6	37,085	7.1	23,415	5.9	17,775	5.9
Total neurological disorders	107,242	7.2	18,577	7.0	42,740	8.2	26,430	6.7	19,495	6.5
Psychiatric disorders:										
Psychosis	37,824	2.5	9,659	3.6	12,345	2.4	9,775	2.5	6,045	2.0
Psychoneurosis	390,609	26.4	47,374	17.8	156,155	30.1	155,285	28.9	71,795	24.1
Character and behavior disorders:										
Pathological sexuality	3,781	0.3	521	0.2	1,550	0.3	1,095	0.3	610	0.2
Asocial and anti-social personality types	1,713	.1	263	.1	455	.1	420	.1	575	.2
Immaturity reactions [3]	49,838	3.5	6,518	2.5	17,820	3.5	14,670	3.7	10,830	3.6
Alcoholism	25,165	1.7	6,040	2.3	7,990	1.5	6,310	1.6	4,825	1.6
Acute	(18,820)	(1.3)	(4,540)	(1.7)	(5,765)	(1.1)	(4,725)	(1.2)	(3,790)	(1.3)
Chronic	(6,345)	(.4)	(1,500)	(.6)	(2,225)	(.4)	(1,585)	(.4)	(1,035)	(.3)
Drug addiction	1,077	.1	152	.1	520	.1	330	.1	75	.0
Enuresis	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	220	.1	190	.1
Total	81,984	5.6	13,494	5.1	28,340	5.4	23,045	5.7	17,105	5.6
Disorders of intelligence	24,357	1.6	3,812	1.4	12,940	2.5	5,360	1.3	2,245	0.8
Other psychiatric disorders	36,716	2.5	5,618	2.1	13,400	2.6	8,420	2.1	9,215	3.1
Total psychiatric disorders	571,490	38.7	80,020	30.1	223,180	43.1	161,885	40.7	106,405	35.7
Total neuropsychiatric disorders	678,732	45.8	98,597	37.1	265,920	51.3	188,315	47.4	125,900	42.2

[1] See footnote 1, table 6, chapter IX.
[2] See chapter XVIII, "Neurology," table 60, for detailed diagnostic distribution.
[3] This diagnosis includes 105 admissions for "pathological personality," not elsewhere specifically classified.

NOTE.—Figures in parentheses are subtotals. The entry .0 indicates a rate of less than .05.

providing for the psychotic or closed-ward type of patient. In 1943, the percent distribution of neuropsychiatric patients in the continental United States by closed and open wards was 43 : 57; in 1944, 29 : 71; and in 1945, 23 : 77. (See chapter IX, "Hospitalization and Disposition," table 10.) However, psychotic disorders constituted during these years only 5.5, 6.0, and 5.7 percent, respectively, of all psychiatric patients hospitalized in continental United States. For the entire World War II period, the psy-

TABLE 15.—*Percent distribution of admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, continental United States, 1942–45* [1]

Diagnosis	Year				
	Total 1942–45	1942	1943	1944	1945
	Neuropsychiatric Disorders				
Neurological disorders:					
Epilepsy	2.1	3.8	2.1	1.6	1.4
Other	13.7	15.0	14.0	12.4	14.1
Total	15.8	18.8	16.1	14.0	15.5
Psychiatric disorders:					
Psychosis	5.6	9.8	4.6	5.2	4.8
Psychoneurosis	57.5	48.0	58.7	61.3	57.0
Character and behavior disorders:					
Pathological sexuality	0.6	0.5	0.6	0.6	0.5
Asocial and antisocial personality types	.3	.3	.2	.2	.5
Immaturity reactions	7.3	6.6	6.7	7.7	8.5
Alcoholism	3.7	6.1	3.0	3.4	3.8
Acute	(2.8)	(4.6)	(2.2)	(2.6)	(3.0)
Chronic	(.9)	(1.5)	(.8)	(.8)	(.8)
Drug addiction	.2	.2	.2	.2	.1
Enuresis	[1] NA	[1] NA	[1] NA	.1	.2
Total	12.1	13.7	10.7	12.2	13.6
Disorders of intelligence	3.6	3.9	4.9	2.8	1.8
Other psychiatric disorders	5.4	5.8	5.0	4.5	7.3
Total psychiatric disorders	84.2	81.2	83.9	86.0	84.5
Total neuropsychiatric disorders	100.0	100.0	100.0	100.0	100.0

See footnote at end of table, p. 261.

TABLE 15.—*Percent distribution of admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, continental United States, 1942–45* [1]—Continued

Diagnosis	Year				
	Total 1942–45	1942	1943	1944	1945
	Psychiatric Disorders				
Psychiatric disorders:					
Psychosis	6.6	12.1	5.5	6.0	5.7
Psychoneurosis	68.4	59.1	70.0	71.3	67.4
Character and behavior disorders:					
Pathological sexuality	0.7	0.7	0.7	0.7	0.6
Asocial and antisocial personality types	.3	.3	.2	.3	.5
Immaturity reactions	8.7	8.2	8.0	9.0	10.2
Alcoholism	4.4	7.5	3.6	3.9	4.5
Acute	(3.3)	(5.6)	(2.6)	(2.9)	(3.5)
Chronic	(1.1)	(1.9)	(1.0)	(1.0)	(1.0)
Drug addiction	.2	.2	.2	.2	.1
Enuresis	[1] NA	[1] NA	[1] NA	.1	.2
Total	14.3	16.9	12.7	14.2	16.1
Disorders of intelligence	4.3	4.8	5.8	3.3	2.1
Other psychiatric disorders	6.4	7.1	6.0	5.2	8.7
Total psychiatric disorders	100.0	100.0	100.0	100.0	100.0

[1] Derived from table 14.

NOTE.—Figures in parentheses are subtotals.

choses comprised 6.6 percent of all psychiatric admissions in continental United States (tables 14 and 15). (See chapter IX, table 9, for the corresponding distributions on worldwide basis and for oversea theaters.) Perhaps, the requirement in some station hospitals that closed-type wards be used for psychoneurotic patients may have contributed to the widespread belief in the Army, during World War II, that all neuropsychiatric patients were "crazy."

In most hospitals, the large general-purpose wards of the W–1 and W–2 variety (fig. 30), which housed general medical and surgical patients, were used for open-ward patients who generally constituted a mixture of neurological, psychoneurotic, personality, and intelligence disorders. These ambulatory patients moved freely about the hospital and were, therefore, able to participate in the arts and crafts and recreational activities in the centrally located Red Cross building.

By no means were all open-ward neuropsychiatric patients admitted to the neuropsychiatric section. A large percentage of patients on the medical, orthopedic, and other wards were primarily adjustment problems with symptoms of organic dysfunction, pain, or discomfort which were mainly of emotional origin. Often, patients with such quasi-organic complaints were retained on the ward and service to which they were initially admitted. When clinical investigation revealed no evidence of organic disease and symptoms persisted, neuropsychiatric consultation was commonly requested. At times, such patients were returned to duty without benefit of neuropsychiatric opinion as soon as it was determined that there was no positive evidence of organic disease.

PERSONNEL

Neuropsychiatrists

From the beginning, there was a shortage of trained psychiatrists, neurologists, psychiatric nurses, attendants, aids, social workers, psychologists, occupational therapists, and recreational therapists. Brief training programs in psychiatry were established for general medical officers, and in spite of the monumental accomplishment of these training programs, the shortage of psychiatrists was never relieved during the entire duration of the war.[6] Graduates of these programs, established by the Surgeon General's Office, were commonly referred to as "90-day wonders." In addition, psychiatrists and other medical and paramedical personnel from numbered station and general hospital units, assigned to the various posts for training, were also used for varying periods in the psychiatric sections of station and regional hospitals. Also, medical officers without even the benefit of professional training programs, but already stationed at a hospital, were often assigned to assist the psychiatrist in carrying his disproportionate load of hospital patients and consultations. In the main, these 90-day wonders and the psychiatrically untrained medical officers, after a short period of supervision, became quite proficient in their psychiatric work and proved to be invaluable. Many of them were to remain in psychiatry after the war. It was estimated that each psychiatrist had approximately twice the patient load of the surgical and medical specialists.

Dr. Eli Ginzberg,[7] Director, Resources Analysis Division, SGO (Surgeon General's Office), believed that the gap between psychiatric means and requirements was never fully appreciated.

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[6] According to William C. Menninger, "Psychiatry in a Troubled World," New York: The Macmillan Co., 1948, p. 238, 2,402 was the greatest number of men assigned to psychiatry, of whom 21 were of professional caliber and 401 board eligible or board certified; 1,251 had had little or no psychiatric training or experience before entering the service.—A. L. A.

[7] Ginzberg, E.: Logistics of the Neuropsychiatric Problem of the Army. Am. J. Psychiat. 102: 728–731, May 1946.

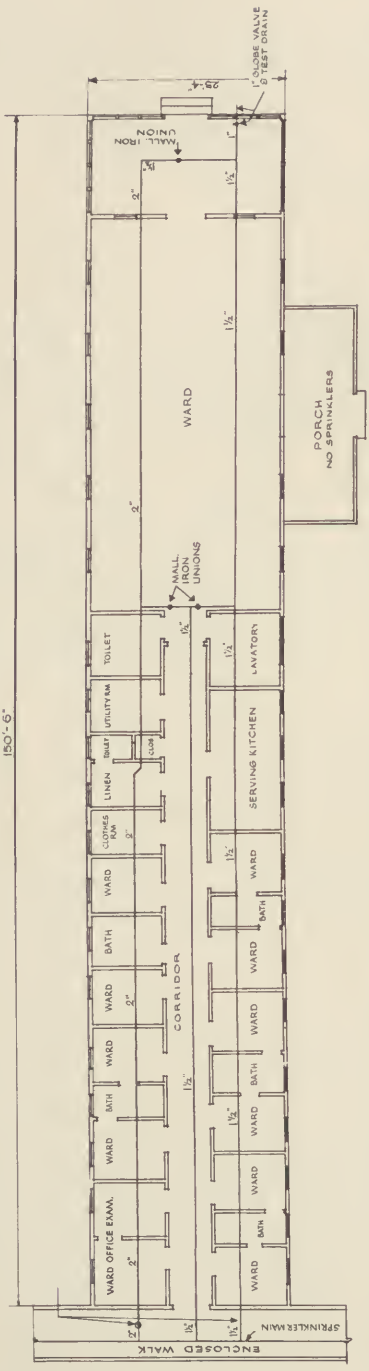

FIGURE 30.—Standard open psychiatric ward identical with ward used for medical, surgical, and other nonpsychiatric patients.

Psychiatric Nurses

Psychiatrically trained nurses were as scarce in the Army as they were in civilian life. Nurses untrained in the care of the mentally ill were assigned to the psychiatric section, many times against their wishes. Some became interested in the challenge and ultimately did outstanding jobs. Others had to be removed and reassigned elsewhere in the hospital. (See chapter XXI, "The Psychiatric Nurse.")

Psychologists and Social Workers

An occasional enlisted man who had had training in psychology or social work would be assigned to the hospital detachment, but for the most part, psychologists and social workers were not available in the neuropsychiatric section of station hospitals until quite late in the war and, then, only in very small numbers.[8] When psychiatric social work and clinical psychology were recognized as military occupational specialties, and personnel with these backgrounds identified, such personnel were, for the most part, assigned to the general and convalescent hospitals.[9]

It was left to the Red Cross to provide most of what social work was practiced in the station hospitals. In some instances, a Red Cross social worker would be assigned to the neuropsychiatric section where she would assist greatly in obtaining histories from patients and relatives, in arranging for disposition of psychotic patients, and, often, in administering simple intelligence or psychological tests.[10] Later on, with the development of the convalescent hospitals, social workers and psychologists participated actively in the treatment program, particularly in group therapy.

In 1946, however, Hutt[11] found that, of 50 psychologists, only 1 was assigned to a regional hospital and 2 to station hospitals. At the Camp Carson, Colo., Station Hospital, an unusually active psychological testing

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[8] Psychiatric social work was formally recognized as a military occupational specialty on 1 November 1943.—A. L. A.

[9] (1) In addition to the psychiatric social work specialty which required a graduate degree in social work from a recognized school of social work or at least 2 years of supervised experience in a private or public agency, a category of psychiatric assistant was established in the WAC (Women's Army Corps) for members of the WAC who had completed 1 year in a recognized school of social work, or who had a college degree or 2 years of college plus 1 year full-time experience in supervised casework. The duties of both types of workers and standards of practice were described in War Department Technical Bulletin (TB MED) 154, June 1945. (2) M. J. Farrell and E. H. Ross, in an excellent review in the *Bulletin of the Menninger Clinic* (8: 153–158, September 1944, entitled "Military Social Work"), trace the entire history of the use of psychiatric social workers in the Army. (3) War Department Circular No. 270, 1 July 1944, provided for the assignment to general hospitals and station hospitals of 1,000 beds or more of clinical psychologists who were commissioned in the Adjutant General's Department and outlined their duties. TB MED 115, 14 Nov. 1944, and changes issued on 19 Mar. 1945, outlined in more detail the clinical psychological service in Army hospitals. (4) War Department Circular No. 71, 6 Mar. 1945, provided for the assignment of clinical psychologists to convalescent hospitals and other psychiatric facilities.—A. L. A.

[10] Feldberg, T. M., and Rosenberg, S. J.: The Psychiatric Social Worker in the Army Station Hospital. Ment. Hyg. 28: 586–595, October 1944.

[11] Hutt, M. L.: Report of Duties Performed by Clinical Psychologists. Bull. U.S. Army M. Dept. 7: 233–237, February 1947.

program was developed.[12] Studies were performed on the underlying emotional problems of enuretics and patients with rheumatic fever; also, correlations were made between psychological tests and clinical diagnosis of illiterate personnel (including mental and educational deficiencies).

Ward Attendants

The enlisted "corpsmen" who were assigned to the psychiatric wards as aids or attendants generally had no prior experience working on psychiatric wards. Formal or informal training programs were established in most hospitals to provide them with the basic understanding and techniques that were required to work with mental patients. Many of those men developed into outstanding technicians. It was not until after the war that their special talents were acknowledged by an official military occupational specialty designation.[13]

Clerical Workers

Secretarial help for the neuropsychiatric section, as well as for other sections and services in the hospital, was provided by civilian employees who were generally recruited from the area in which the hospital was located.

CLINICAL PROBLEMS

The psychoneuroses were the most common emotional disorders. This holds true whether the distribution of the psychiatric disorders are viewed on a worldwide basis, or separately by continental United States and oversea theaters. (See chapter IX, table 6, for the admissions and admission rates for neuropsychiatric disorders on worldwide basis, and table 14, this chapter, for the corresponding data in continental United States.) Psychoneurotic disorders composed 69.8 percent of all psychiatric disorders on a worldwide basis, 68.4 percent in continental United States, and 72.2 percent in oversea theaters (chapter IX, table 9).

Next in magnitude were immaturity reactions, closely followed by psychoses. Immaturity reactions constituted 7.3, 8.7, and 4.7 percent of all psychiatric disorders on a worldwide basis, in the continental United States, and in oversea theaters, respectively. The corresponding percentages for psychosis were 7.3 percent, 6.6 percent, and 8.3 percent (chapter IX, table 9).

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[12] Greenwood, E. D., Snider, H. L., and Senti, M. M.: A Psychological Testing Program in an Army Station Hospital. Mil. Surgeon 95: 489–495, December 1944.

[13] War Department Circular No. 209, 13 July 1946.

Psychotic Disorders

Hecker and his associates[14] reported their findings in the 10-month period preceding the onset of the war. Working in a typical 800-bed station hospital in the United States, serving 17,000 troops in training, they found that the majority of patients with psychoses were admitted within the first 6 months of their service. In many cases, excitement and panic were found to be predominant with rapid improvement on hospitalization and, in some cases, seeming complete recovery after discharge.

Observations by other psychiatrists were in wide agreement on both the tendency for early occurrence of psychotic episodes and the better immediate prognosis. Many cases of brief transient psychotic episodes were seen in the Army and reported by various workers.[15] These were not the psychoticlike reactions that were described as occurring in combat.

It was rare to retain a man in the service who suffered a psychotic breakdown. Regulations and other directives necessitated his discharge even upon recovery.[16] Many patients recovered promptly upon returning to their homes and were able to return to civilian employment.[17] It is estimated that 60 percent of all psychotic patients recovered within a period of 2 to 3 months from the time of onset of the illness.[18]

In general, the incidence of psychotic reactions was much higher in men with less than a year of military service than in those with 2 or 3 years.[19] Cases of psychosis were apt to manifest themselves early or develop promptly in markedly predisposed individuals. In the series of 48 cases studied by Hecker and his associates, approximately one-third were hospitalized during their first month of service. Similarly, Hitschmann

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[14] Hecker, A. O., Plesset, M. R., and Grana, P. C.: Psychiatric Problems in Military Service During the Training Period. Am. J. Psychiat. 99: 33–41, July 1942.

[15] (1) Porter, William C.: Psychiatry in the Army. *In* Psychiatry and the War (edited by F. S. Sladen). Springfield: Charles C Thomas, 1943, p. 245. (2) Malamud, W., and Malamud, I.: Sociopsychiatric Investigation of Schizophrenia Occurring in the Armed Forces. Psychosom. Med. 5: 364–375, October 1943. (3) Klow, S. D.: Acute Psychosis in Selectees. Illinois M.J. 83: 125–130, February 1943. (4) Brosin, H. W.: Symposium on Psychiatry in the Armed Forces: Panic States and Their Treatment. Am. J. Psychiat. 100: 54–61, July 1943.

[16] Brill, N. Q., and Walker, E. F.: Psychoses in the Army; Follow-Up Study. Bull. U.S. Army M. Dept. 79: 108–115, August 1944.

[17] Circular Letter No. 99, Office of The Surgeon General, U.S. Army, 4 Sept. 1942.

[18] (1) Menninger, *op. cit.*, pp. 174 and 598. (2) That most patients with acute psychotic disorders probably "recovered" was a common impression of psychiatrists during World War II. However, no followup studies have been accomplished to determine if the remission of psychotic symptoms was maintained. The studies of Ripley and Wolf relative to similar acute psychotic disorders occurring in a combat theater do not indicate such a benign prognosis: "A group of 341 patients with acute schizophrenic reactions treated in a combat zone overseas were followed up 5 to 8 years later. Despite removal from the environment in which the illness occurred and discharge from the service, 51 of the patients had to be rehospitalized for their psychosis; 186 of the patients were still considered to be moderately or markedly disabled by their mental illness 5 or more years after the original episode. These findings would appear to contradict the widely held notion that these 'acute battle reactions' are of a relatively benign and transitory nature. In fact, the illness does not seem to differ significantly from schizophrenia encountered in civilian life" (Ripley, H. S., and Wolf, S.: Course of Wartime Schizophrenia Compared With Control Group. J. Nerv. & Ment. Dis. 120: 184–195, September-October 1954).—A. J. G.

[19] Menninger, *op. cit.*, p. 170.

and Yarrell[20] reported that 23 percent of psychotic patients became ill within 2 weeks of starting training in the Army and 70 percent developed their illness in the first 5 months of service.[21]

Officers who were, in general, more carefully screened than were enlisted men had a lower incidence of psychotic disorders[22] (table 16). The highest rate of psychosis was in enlisted women who were not screened psychiatrically in the early part of the war.[23] It is not known if the incidence of psychotic reactions was higher in the Army than in civilian life.

TABLE 16.—*Admission rates for psychiatric conditions, by rank, U.S. Army, worldwide, 1942–45* [1]

[Rates per 1,000 mean strength per year, by rank]

Diagnostic category	Total [1]	Officers	Enlisted personnel
Psychosis	2.7	1.1	2.9
Psychoneurosis	25.6	15.1	26.7
Character and behavior disorders	4.7	1.7	5.0
Other psychiatric disorders	3.7	2.5	3.8
Total psychiatric disorders	36.7	20.4	38.4

[1] See chapter IX, table 6.

Nonpsychotic Disorders

Other psychiatric problems which often resulted in hospitalization were reactive depressions, homesickness, "gold-bricking," situational maladjustments, emotional immaturity, enuresis, somnambulism, and alcoholism. The magnitude of these problems and their military significance have been comprehensively reviewed by Menninger.[24] It was commonly observed that the breakdown rate, particularly with psychoneurotic reactions, reached a peak after 3 or 4 weeks of basic training. It was this early period of training at replacement training centers and in tactical units that constituted the first serious hurdle for the new soldier.[25] At the Camp

[20] Hitschmann, M., and Yarrell, Z.: Psychoses Occurring in Soldiers During a Training Period. Am. J. Psychiat. 100: 301–305, November 1943.

[21] In general, it is well documented, even before World War II, that psychotic disorders in military personnel arose early in their military career, usually 50 percent within the first year. However, it should be noted that the findings made herein were related to soldiers new to the service, therefore any psychiatric disorder arising from this newly inducted group would perforce be found to occur early in the service. Thus the appearance of psychosis from these new soldiers was more a characteristic of the group studied than of the disease itself.—A. J. G.

[22] There is no evidence to support the implication in this statement that officers were more carefully "psychiatrically" screened than enlisted men. However, the incidence of psychosis in officers, which has also been a constant finding in peacetime, is most probably related to the screening process relative to requirements for commissioning such as age, intelligence level, and educational background.—A. J. G.

[23] Author's own impression. There are no available data to support this statement.—A. J. G.

[24] Menninger, *op. cit.*, pp. 175–190.

[25] Halloran, R. D.: Problems of Neuropsychiatry in the U.S. Army. M. Ann. District of Columbia 13: 17–23, January 1944.

Maxey, Tex., Regional Hospital, most cases were mild neurotics with various somatic manifestations. Sore backs, stomach aches, and headaches predominated.

The inadequate soldier was another outstanding problem. This type of soldier rapidly developed somatic symptoms along with complaints and appearance of weakness.[26] Intensive therapeutic interviews and suggestive therapy accomplished very little in changing these patterns.[27] The commanding officer of the hospital, commenting on other types of problems encountered, stated:

> The psychopaths are a heterogeneous lot and our consciences sometimes hurt when we recommend a discharge for undesirable habits and traits of character, for many of these men are as much out of control as the psychotic. * * * A related problem is the criminal soldier. * * * We are now required to see all the prisoners that come up for general courts-martial. It is our impression that routine punishment and discipline has very little effect on most prisoners whom we see and it is encouraging to note that many more of the men are being sent to reconditioning centers where they may receive skilled help for evaluating their problems.
>
> Another complex group includes the homosexual soldiers. * * * Success [in treating them] is questionable.
>
> The majority of psychotic patients have schizophrenic reactions combined with considerable affect. These reactions are transient and less severe than what we have seen in civilian life.

He also commented on the strong trend so many patients showed to remain in the hospital and stated that the reconditioning annex was a logical attempt toward correcting this strong desire toward remaining ill. He believed that their major accomplishment had been emphasis on outpatient care, working with junior line officers and noncommissioned officers in going over specific problem cases. Their policy was to return the questionable or mild cases to duty and then help the officers in the unit to better deal with these men.

Menninger,[28] while agreeing that anxiety reactions were the most common neurotic disorders seen and schizophrenic reactions the most common type of psychosis, emphasized the importance of the problem of mental retardation and the lack of special battalions for persons so handicapped. He also called attention to the common occurrence of clinical pictures rarely encountered in civilian practice—severe nostalgia and enuresis in adults. While true malingering was rare, it was seen (or suspected) more frequently than in civilian life. He observed that individuals with psychosomatic complaints constituted a large portion of the practice in the gastrointestinal, cardiac, and orthopedic services. The so-called neurocirculatory asthenia was observed frequently—but too often regarded as having an entirely organic basis.

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[26] In World War II, such cases were often dubbed the "PMS (poor miserable soul) Syndrome" because of the persistent clinical picture of multiple and shifting somatic complaints, weakness and overall helplessness, and inadequacy in performing even menial tasks.—A. J. G.

[27] Annual Report, Regional Hospital, Camp Maxey, Tex., 1944.

[28] Menninger, W. C.: Psychiatric Problems in the Army. J.A.M.A. 123: 751–754, 20 Nov. 1943.

Psychosomatic disorders.—The need to recognize and evaluate properly the large number of patients with psychosomatic disorders was stressed by Pignataro.[29] Such patients were commonly looked upon by medical officers as "gold bricks" and were returned to duty "only to oscillate between their companies and the hospital until, in disgust, their commanding officers sloughed them off or until a medical officer finally discharged them."[30]

It was suggested by Menninger that such mistakes were related to emotional problems in the physicians who became irritated, annoyed, and at times vindictive toward the patient.[31] Too often, there was an attitude that, unless there was some surgical, mechanical, or medicinal treatment, nothing could be done.

Except for special studies in individual installations there were no means of determining the extent to which patients with primary psychogenic disorders were initially hospitalized or observed for "organic" pathology. A cursory study of consecutive cases observed in the gastrointestinal and cardiovascular services of 7 station and 11 general hospitals in the Zone of Interior in 1944 gave some indication of the probable extent of the problem. Under the "organic" category were placed those cases that had demonstrable tissue pathology. In the "functional" category were included those cases with a specific diagnosis of psychoneurosis or a condition believed to be predominantly psychogenic and without demonstrable tissue pathology. Of 1,000 cases in the station hospitals, 35.5 percent were categorized as functional, and of 3,242 cases in the general hospitals, approximately 22 percent were considered functional.[32]

Inpatient Workload

In May 1945, the peakload of neuropsychiatric patients in hospitals in the continental United States was 37,640 (see chapter IX, table 10). At that time, 5,871 closed-ward beds and 7,238 open-ward beds were authorized for psychiatry in all the general and special hospitals. In addition, there were 17,000 beds in convalescent hospitals and 6,000 in regional and station hospitals.

During 1942, there were some 99,000 admissions for neuropsychiatric conditions in continental United States; 266,000 in 1943; 188,000 in 1944; and 126,000 in 1945. Altogether, there were in the continental United States some 679,000 admissions for neuropsychiatric conditions (table 14). (For corresponding data on a worldwide basis, see chapter IX, table 6.)

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[29] Pignataro, F. P.: Psychosomatic Medicine in Military Practice. Mil. Surgeon 89: 632–638, October 1941.

[30] Menninger, W. C.: Psychiatric Problems in Army Hospitals. Bull. U.S. Army M. Dept. 71: 31–42, December 1943.

[31] (1) Menninger, W. C.: Relationships of Neuropsychiatry to General Medicine and Surgery in the Army. Mil. Surgeon 96: 134–138, February 1945. (2) Bauer, W., and Brosin, H. W.: The Importance of Preventive Psychiatry in Psychosomatic Medicine. [Unpublished manuscript.]

[32] Annual Report, Neuropsychiatry Consultants Division, Office of The Surgeon General, 1944–45.

Characteristics of Hospitalized Psychoneurotic Enlisted Men

After the war, a followup study of war neuroses was undertaken as part of the program of studies of the Follow-Up Agency of the National Research Council developed by the Committee on Veterans Medical Problems in cooperation with the Veterans' Administration, the Army, and the Navy.[33] Approximately 1,000 men, aged 18–25, who had been hospitalized for psychoneurotic disorders in the service were studied. From the data obtained, it was possible to reconstruct some of the characteristics of this group which distinguished it from a cross section of the military population.

Those who had been admitted for psychoneuroses were a little older at entry into service, a little more often married because they were older, and, possibly, a little more often from 1 of the 13 largest metropolitan districts of the country. They did not differ as to intelligence, civilian occupation, religion, or race. It was found, however, that men with a lower educational attainment had a greater chance of breakdown. The estimated admission rates for those who completed less than 5 grades was 80 per 1,000 per year, while the rate for those who had completed from 13 to 15 grades was somewhat under 20 per 1,000 per year.

The admission rate for psychoneurosis during the first month of service was double the rate for the average length of service before hospitalization, reaching a low point in the second year and peaking again after 4 years of service.

Fewer psychoneurotics, than the cross section of the Army, served overseas. The relative frequency of courts-martial was about 60 percent higher for the psychoneurotics. As a group, they were AWOL (absent without leave), confined, or incapacitated about 1 percent of the time. Multiple hospital admissions for psychoneuroses were common, and the duration of hospitalization greatly exceeded that of admissions for disease generally (not including wounds).

Stresses such as domestic difficulty, economic hardship, anxiety over entry into the service, homesickness, and fear of impending shipment overseas were perceived as stresses more often in men whose psychoneuroses occurred in the Zone of Interior. Lack of comforts, change in diet, and food deprivation were also factors in some of the early breakdowns, although there is reason to question the objective severity of such stresses in these men.

The average length of service before initial hospitalization for psychoneuroses in those cases that developed in the Zone of Interior was 11.7 months, with 8.1 months served after "breakdown." Part of the 8.1 months, however, was spent in hospitals. Of the men with a Zone of Interior breakdown, 72 percent were given a medical or administrative discharge (the latter only rarely), half without ever being returned to duty.

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[33] Brill, Norman Q., and Beebe, Gilbert W.: A Follow-Up Study of War Neuroses. Veterans' Administration Monograph. Washington: U.S. Government Printing Office, 1955.

Only 17 percent of the men who were hospitalized while in a training center were ever sent overseas.

Analysis of these followup data revealed that it was the man with a positive history of psychiatric disorder in one or both parents and, in addition, with an excessively strong positive attitude toward his mother who was most apt to break down in the Zone of Interior (if he broke down at all). There were 30 men so classified, and 70 percent of them broke down before going overseas.

Many other variables were studied to determine which preservice characteristics were associated with early breakdowns as contrasted with late breakdowns; that is, in or after combat. Economic status of the individual's parental family, role of religion in the life of the parental family, presence of overt sibling rivalry, parental conflict, parental withdrawal via death or divorce, and order of birth seemed to play no part.

Of those who broke down in the Zone of Interior before any oversea service, 37 percent had strongly positive family histories of emotional maladjustment or illness in contrast to 25 percent with negative family histories.

Not all of those who broke down early gave histories of previous emotional difficulty. As far as could be concluded from careful examination and review, 19 percent of those in the followup sample, who were clinically "normal" before service, broke down early. Of the men studied who had suggestive or overt neuroses before induction, 60 percent broke down in the Zone of Interior. It must be emphasized that this does not mean that 60 percent of all soldiers with suggestive or overt neuroses before service were hospitalized for psychoneuroses in the Zone of Interior—but of those who did break down, hospitalization was apt to result early in the person's military career if he had a "positive" past history. Of interest is the fact that a significant number of those with positive past histories were known to have rendered effective service, up to and including combat, before becoming disabled.

Further information relative to the prevalence of neurotic predisposition was obtained from a study made by the Research Branch of the Information and Education Division, War Department, in collaboration with the Neuropsychiatry Consultants Division, of the Surgeon General's Office. This study, which involved a personality survey of a sample of all military personnel in the continental United States, found that the incidence of what had previously been regarded as neuropathic traits (for example, history of bed wetting or thumbsucking) was so high among men performing duty that these traits could no longer be regarded as in themselves highly significant. Similar findings were obtained from battle casualties and men performing combat duty. It is believed that some psychiatrists, not having the benefit of service in combat theaters, medically reclassified

and discharged many men who could have rendered effective service had they been retained.[34]

DISPOSITION

Early Policies

During the period of mobilization and in the early part of the war, a psychiatric patient was hospitalized in a station hospital located on or nearest the post where he was on duty. Army policy was to dispose of such patients as soon as a definitive diagnosis was made. In this vein, a directive from the Surgeon General's Office[35] stressed that disposition need not be delayed until a highly accurate diagnosis was established by prolonged and detailed study, as follows: "If an individual is obviously unfit, the psychiatrist should make the best tentative diagnosis and proceed promptly with the necessary action to dispose of the patient."

The Army was concerned with building and maintaining a healthy and effective fighting force and left the burden of treating noneffectives to the Veterans' Administration and other civilian agencies.[36]

Early in the expansion of the general hospital system, provision was made for specialist care in general hospitals of surgical and medical cases requiring long-term treatment or special procedures. Psychiatric patients, however, continued to be "disposed of locally" except in the case of officers and of enlisted men with over 20 years of service and where no psychiatrist was available.[37] These were to be transferred to the nearest general hospital.

On 11 March 1942, The Surgeon General announced the opening of Darnall General Hospital in Danville, Ky., a mental hospital leased from the State of Kentucky. It was the first of two general hospitals which were to be used strictly as psychiatric hospitals. (Mason General Hospital, Brentwood, Long Island, N.Y., was the second.) In June 1942, when sufficient other general hospitals had been opened, Darnall General Hospital was designated to receive only certain psychotic patients (nurses and enlisted men) when transfer would place them nearer to their homes than transfer to a nearby hospital.[38]

Delays in Transfer and Discharge

Up until March 1943, when Public Law No. 10, 78th Congress, granted the status of "a veteran of any war" to all militarized persons who served

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[34] Annual Report, Neuropsychiatry Consultants Division, 1944–45, pp. 114–117.

[35] See footnote 17, p. 266.

[36] Halloran, R. D., and Farrell, M. J.: The Function of Neuropsychiatry in the Army. Am. J. Psychiat. 100: 14–20, July 1943.

[37] Circular Letter No. 6, Office of The Surgeon General, U.S. Army, 24 Jan. 1942.

[38] Circular Letter No. 61, Office of The Surgeon General, U.S. Army, 27 June 1942.

on or after 7 December 1941, psychotic patients could be transferred to Veterans' Administration hospitals only when their illnesses were "in line of duty." The vast majority of cases were considered "to have existed prior to induction" and were therefore not eligible for veterans' hospital care. When in need of continued hospitalization on discharge, application to the various State agencies was required. It was unusual to dispose of a psychotic patient sooner than 2 months after admission to an Army station hospital. Some psychiatric patients were not transferred for more than 3 to 5 months during 1941–43 because their home States refused to accept responsibility for prolonged care. During this time, when active therapy would have been most effective, it was not possible to provide such treatment except that which could be improvised with the existing facilities and with the approval of hospital commanders.

The procedure to dispose of psychotic patients was extremely complex and cumbersome, and often, psychiatrists who were unfamiliar with all the directives and methods encountered marked difficulty and delay in disposing of their patients. Porter [39] had called attention to this even before the start of the war and had recommended elimination of the AR 600-500 [40] board, the so-called Army Insanity Board. Patients had to be examined by such boards and also by CDD (certificate of disability for discharge) boards;[41] families had to be contacted and their desires ascertained (that is, if they wished to arrange for further treatment themselves); State agencies had to be written to, and often, no reply was received for weeks. Where efforts to dispose of patients to relatives and State agencies were unsuccessful, commitment boards had to be appointed and convened and application made through channels to transfer patients to St. Elizabeths Hospital in Washington, D.C. This entire procedure is described in detail by Farrell.[42]

Other factors contributing to the delays in disposition were related to the discharge system. Patients admitted to station hospitals continued to belong to their organizations. The CDD form initiated by the hospital had to be forwarded to and signed by the patient's commanding officer who often was not familiar with the procedure and took an excessive amount of time in returning the form to the hospital. In some instances, the patient's service record was with his unit which had already been transferred to another post or shipped overseas, and this had to be obtained before discharge could be processed.

As a result, there was a gradual accumulation of mental patients in Army hospitals to the point where it constituted a major logistic problem. The problem was further complicated as the war progressed by the need

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[39] Memorandum, Lt. Col. William C. Porter, MC, for Col. Albert G. Love, MC, Assistant to The Surgeon General, 29 Feb. 1940.

[40] Army Regulations No. 600–500, 25 May 1944.

[41] Army Regulations No. 615–361, 4 Nov. 1944.

[42] Farrell, M. J.: Military Laws and Regulations Pertaining to Disposition of Neuropsychiatric Casualties. *In* Manual of Military Neuropsychiatry. Philadelphia: W. B. Saunders Co., 1945, p. 71.

to care for psychotic prisoners of war. Mason General Hospital which was opened in June 1943 was designated to receive them.[43]

Elimination of delays.—When transfer to Veterans' Administration hospitals was authorized by law, regardless of line of duty, the long delay that was incident to corresponding with the State agencies was, for the most part, eliminated, and dispositions became more rapid.

In January 1944,[44] in addition to Darnall General Hospital, Mason General Hospital, Bushnell General Hospital, Brigham City, Utah, and Valley Forge General Hospital, Phoenixville, Pa., were designated as centers for specialized care of psychotic patients and for those neuropsychiatric cases which involved special diagnostic or treatment problems. Such centers had been recommended by Ebaugh[45] as early as 1941. However, the majority of neuropsychatric patients were still disposed of locally by the station hospitals.

Return to Duty

The extent to which neuropsychiatric patients were returned to duty from Zone of Interior hospitals cannot be determined. Any statistical figure would be of questionable value since there were certain variables affecting the return to duty rate, and these variables were, in part, based on administrative policies rather than on medical criteria. In addition, the increasing use of consultation services for diagnosis and outpatient treatment tended to decrease admissions of personnel who, if admitted to hospitals, would conceivably be returned to duty. However, it is believed that, beginning in the latter part of 1944, the frequency of return to duty increased as a result of directives which stated that the existence of a psychoneurosis was not sufficient reason for discharge but, rather, that discharge should be accomplished only if the patient's illness actually incapacitated him for service. In addition, the increase in facilities for and the emphasis upon definitive treatment throughout 1944 were effective in returning a greater percent to duty than had been accomplished previously.[46]

How many patients were returned to duty was clearly related to the perspective and viewpoint of the psychiatrist responsible for the treatment of the soldier with an emotional or functional disorder. Most psychiatrists carried with them into the service the traditional civilian physician's concern about his patient and his well-being and comfort. What is best for an individual in the service, however, is not always best for the Army. Combat is very unhealthy and often fatal and, if just the patient's immediate welfare were the sole concern of the military psychiatrist, he would prescribe removal from combat for everyone. While this, of course, did not occur,

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[43] War Department Circular No. 214, 15 Sept. 1943.

[44] War Department Circular No. 12, 10 Jan. 1944.

[45] Ebaugh, F. G.: Symposium on Medical Preparedness; Role of Psychiatry in National Defense. J.A.M.A. 117: 260–264, 26 July 1941.

[46] Annual Report, Neuropsychiatry Consultants Division, 1944–45, p. 44.

many psychiatrists were preoccupied with removing patients with emotional difficulties from stress. They did not always appraise realistically the degree to which psychiatric disorders impaired a person's effectiveness, often underestimating a soldier's ability to render effective service in spite of personality defects. Psychiatrists in combat units were better able to observe the powerful positive effect of good motivation and leadership and more quickly revised their concepts. They were able to observe, firsthand, how individuals with psychoneurotic or personality disorders were able to render prolonged effective service under most intense stress of combat.

TREATMENT

Early Experiences

As late as May 1944, AR 615–360 specifically stated: "Individuals permanently unfit for Army service because of neuropsychiatric disturbances will not be retained for definitive treatment, but will be discharged and arrangements will be made for further care by the Veterans Administration if such is indicated." However, due to delay in transfer and discharge and the consequent accumulation of patients, most hospitals, during 1942–43, on their own initiative and with considerable ingenuity, developed activity programs for as many patients as possible. Those patients who could not be quickly transferred often received considerable attention in order to make possible their transfer. However, even though psychiatrists attempted to treat as many patients as possible, they were hampered by the large number of patients they were called upon to see and by the lack of facilities. In a few hospitals, there were no *organized* therapy programs for either open- or closed-ward patients during the early years of the war.

"Too Little and Too Late"

Individual attention was given to the more seriously ill patients; wet-packs were used to quiet agitated patients, sedation was prescribed when indicated; the occasional patient with a conversion reaction was rendered symptom free through the use of suggestion, often with Sodium Amytal (amobarbital sodium) narcosis. As time went on, ball games and daily calisthenics were arranged; entertainment was brought to the closed wards. In a few hospitals, occupational therapy shops were improvised out of warehouses or unused wards, salvaged material, and equipment which could be purchased with hospital funds. It was generally impossible to obtain sufficient personnel to cover the neuropsychiatric wards, and most of what was done in the way of recreation, entertainment, and occupational therapy through 1943 was possible only because of the assistance and cooperation of the Red Cross or local Gray Ladies.

Electroshock treatment was not authorized until the spring of 1943,

when its use in selected cases of psychoses was approved.[47] However, many hospital commanders were reluctant to introduce such "dangerous" treatment in their hospitals, and equipment for such treatment could not be requisitioned. Furthermore, in many of the smaller hospitals, personnel trained in giving shock treatment were not available.

In too many installations, the small neuropsychiatric section was looked upon as a necessary evil. Occupational therapy, when finally authorized in August 1943, was approved only for general hospitals in the Zone of Interior, but not for station hospitals where arts and crafts and hobby activities were continued by Red Cross workers. It became increasingly apparent that, if proper treatment were to be given psychiatric patients, they would have to be concentrated in specially designated centers where trained personnel could be used most economically. This eventually came about with the establishment of regional hospitals in April 1944[48] and the designation of additional general hospitals as neuropsychiatric centers.[49]

Special Programs

It had been recognized for a long time that many persons who were hospitalized for psychoneurotic disorders did not require hospitalization and, in fact, did poorly in hospitals.[50] Medical officers, however, had no other recourse. If a man were not fit for duty because of a psychoneurosis, the only possible disposition was to send him to a hospital. In civilian life, hospitalization would not even have been considered.[51]

Great ingenuity was used by many medical officers, however, in developing treatment programs that were designed to return to duty as many psychiatric patients as possible. For example, Col. Thomas G. Tousey, MC, commanding officer of the Station Hospital, Camp Kilmer, N. J., established a rehabilitation program for men who developed emotional symptoms at the staging area in which his hospital was located. Before establishing this program, Colonel Tousey had determined that, when such men were given medical discharges for psychoneuroses, 69 percent were able to readjust themselves and become gainfully employed almost immediately after returning to civilian life.

By not using a formal diagnosis of psychoneurosis in these cases who "broke down" just before oversea shipment and by assigning those who could not be returned to duty to the hospital medical detachment, continued medical observation could be carried out while these men lived in barracks and worked in the hospital or were on a nonpatient status. By gradually

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[47] Circular Letter No. 88, Office of The Surgeon General, U.S. Army, 23 Apr. 1943.

[48] War Department Circular No. 140, 11 Apr. 1944.

[49] War Department Circular No. 235, 12 June 1944.

[50] Menninger, W. C.: Problems Confronting Psychiatry in the Army Convalescent Hospital. Am. J. Psychiat. 102: 732–34, May 1946.

[51] Farrell, M. J., and Appel, J. W.: Current Trends in Neuropsychiatry. Am. J. Psychiat. 101: 12–19, July 1944.

increasing their responsibilities and the demands made on them to restore their self-confidence, it was possible to return 83 percent of these patients to general or limited service. A considerable number were assigned directly to task forces departing from the staging area or to other posts to join units that were preparing to go overseas. Only 17 percent had to be discharged. Followup on those who were returned to duty revealed that only five men were hospitalized and three of these again returned to full duty. This program was described in detail by Goldbloom and Schantz.[52]

Col. Lauren H. Smith, MC,[53] Neuropsychiatric Consultant, Ninth Service Command, was impressed with how much individual psychiatrists were able to do in the way of developing treatment programs which, he believed, compared favorably with those of civilian hospitals.

Treatment Officially Directed

Circular Letter No. 168, Office of The Surgeon General, issued on 21 September 1943, prescribed a convalescent reconditioning program for hospitals. Its objective was to return men to duty from hospitals in the best possible physical condition and the constructive use of leisure time in educational pursuits. However, no special provisions for neuropsychiatric patients were included.

In general, little was done previously to develop reconditioning programs in hospitals, and on 10 December 1943, The Surgeon General sent a memorandum to all service command surgeons and commanding officers of all named general hospitals, ordering that reconditioning programs be put into effect at once for all patients regardless of whether or not they were expected to return to duty.

On 1 April 1944, War Department Technical Bulletin (TB MED) 28, the first comprehensive directive on the treatment of psychiatric patients, was issued, and for the first time, it was officially directed that psychiatric patients be treated:

> The acute needs for manpower make it imperative that every treatment method available in station and general hospitals for neuropsychiatric patients be utilized to the maximum. The aim is to salvage every possible soldier for further duty. Those patients in whom there is no hope for salvage should be recommended for discharge.
>
> *a.* An erroneous attitude prevails that neuropsychiatric patients should not be treated, perhaps because of misinterpretation of previous directives. In too many hospitals, neuropsychiatry is merely a matter of diagnosis and disposition. This must be corrected: the soldier receives the best of medical and surgical treatment, and the neuropsychiatric patients should be given the benefit not only of treatment but of the most scientific methods available. "Those individuals with neuropsychiatric conditions incurred incident to the service who, in the opinion of the medical officer, may, within

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[52] (1) Goldbloom, A. A., and Schantz, B. A.: The Management of the Emotionally Maladjusted Soldier at a Staging Camp. Psychiatric Quart. 20: 452–469, July 1946. (2) See also chapter XII, "Troops in Transit."

[53] Smith, L. H.: Treatment Activities in War Psychiatry. Am. J. Psychiat. 101: 303–309, November 1944.

a reasonable period be returned to duty within the continental limits of the United States" are to have definitive treatment (AR 615–360, Changes No. 16, 15 December 1943). A high percentage of psychoneurotic patients can be salvaged, if treated, and the possibility of their salvage can be determined only by treatment.

b. There is a tendency to misuse the diagnostic term "psychoneurosis." On the other hand, under sufficient stress of a specific type, any individual may develop a psychoneurotic disorder. Consequently, the presence of psychoneurotic symptoms may indicate an extremely difficult situation rather than a "weak" individual.

c. A widespread attitude prevails on neuropsychiatric wards that admission to such wards is tantamount to discharge. This attitude spreads, with infectious virulence, to new patients. Effective steps must be taken by medical officers and all ward personnel to reverse this attitude through individual and group contacts and segregation.

Many important principles of treatment were outlined, such as:

Psychotic and psychoneurotic patients should not be housed in the same ward, except in those occasional instances where active suicidal trends may be present in a psychoneurotic patient.

Prisoners, unless neuropsychiatric cases themselves, are not to be housed with neuropsychiatric patients, and in no instance is the guard on a neuropsychiatric ward to be armed with a firearm.[54]

Depending upon the number of patients and wards available, all open neuropsychiatric wards, with the exception of one for acute cases and new admissions, might be located in military barracks, with an attempt to divorce the patients from a "hospital atmosphere." The patients in such wards should be dressed in uniform or fatigue clothes, and required to do their own police work, take care of the ward, and their own beds and property, and care for themselves.

Obtain the "permanent" assignment of as many nurses as possible with neuropsychiatric nursing training and/or experience to the neuropsychiatric section.

Exercise care in the selection of ward attendants to the end that—

(1) Neuropsychiatric patients be in charge of intelligent and emotionally stable individuals capable of contributing to their effective therapeutic management.

(2) Individuals with special skills in sports, crafts, games, and music, especially those capable of leadership in such activities, be utilized to the fullest extent.

Enlist as much aid from the Red Cross as possible.

Recreation workers especially can be of major help in the development of an activity program.

Gray Ladies, under the supervision of the Red Cross, can be of such help as instructors, and can assist in the recreation program and provide individual attention.

Enlist the part-time or occasional help of other medical, dental, and medical administrative officers and nurses in the leadership of special classes or group activities in their particular hobbies or interests (chess, photography, aviation, art, etc.).

In general hospitals, full utilization of the gymnasium and the occupational therapy shop should be made. In station hospitals, if no separate space is available, a craft workshop can be established on the porch or dayroom of a ward. Every ward or group of patients (including psychotic) should have an adequate outdoor recreation area, sufficiently large to permit active group games. An area for vegetable or flower gardening is desirable.

Every neuropsychiatric patient should have psychotherapy.

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[54] This provision was reinforced by a letter from Brig. Gen. Raymond W. Bliss, Chief of the Operations Service of the Surgeon General's Office, to the service command surgeons, dated 5 June 1944, in which it was directed that prisoners not be confined on neuropsychiatric wards and that members of the medical detachment not be confined or assigned to the neuropsychiatric section for disciplinary purposes (a practice that was followed in some hospitals).

Group psychotherapy was encouraged. The indications and technique of psychotherapy under sedation with Sodium Amytal and Sodium Pentothal (thiopental sodium) were given. The development of a well-rounded and scheduled occupational-recreational-educational activities program was urged. Authority for the use of shock therapy was restated and utilization of hydrotherapy encouraged.

The publication of TB MED 28 can be attributed to the personal efforts of Brig. Gen. William C. Menninger. Previously, as a neuropsychiatric consultant in the Fourth Service Command, he had urged that neuropsychiatric patients be given every possible benefit of treatment. However, it was this War Department directive which made possible the Army-wide adoption of a treatment program which was to continue to expand during the remainder of the war. The importance of this was described by Thomas [55] and many others.

Army Service Forces Circular No. 175, issued on 10 June 1944, provided for the extension of the reconditioning program to include the majority of neuropsychiatric patients, as follows:

> Experience has shown that the majority of patients with mental and emotional upsets are benefited by the prompt institution of a planned program which prevents apathy, morbid introspection and preoccupation with the somatic manifestations of emotional disturbances. Prolonged hospitalization tends to fix the symptoms rather than alleviate them. In order to achieve the maximum benefit, any patient who has even a remote chance for salvage for additional military service will be given a trial at reconditioning.
>
> As soon as the necessary investigative procedures have been completed, all patients who do not require closed ward care or intensive individual therapy will be assigned to the advanced reconditioning section and housed apart from the hospital wards. Care will be exercised that disturbed or suicidal patients will continue to receive appropriate ward care.
>
> Patients will be organized into separate platoons and placed in duty uniforms, grouped so far as possible on the basis of the degree of their incapacity.
>
> An organized program of physical conditioning, educational reconditioning, occupational and industrial therapy, and active recreation will be planned. Group psychotherapy will be utilized to its full effect.
>
> The reconditioning program for many neuropsychiatric patients will constitute their only treatment in contrast to medical and surgical cases where active therapy has given way to convalescent care. Such reconditioning will include individual and/or group psychotherapy and participation in prescribed activities designed to overcome neuropsychiatric defects. Programs for these patients, therefore, will be formulated and carried out with the approval and active assistance of the psychiatrist.
>
> Convalescent neuropsychiatric patients who have been judged fit to return to duty may be combined, when it is desired, with other trainees in the advanced reconditioning sections.
>
> If it is found impractical to conduct a program of reconditioning for neuropsychiatric patients at a hospital because of the smallness of the group, they may be sent to another hospital or facility at the direction of the service command.
>
> Full use should be made of the treatment program for psychiatric patients outlined

[55] Thomas, H. M., Jr.: Convalescent Care and the Morale of Patients. Mil. Surgeon 93: 453–457, December 1943.

in TB Med 28, 1 April 1944 * * *. Attention is also directed to the need for proper reclassification and selective assignment to duty which the neuropsychiatric patient may be expected to perform * * *.

The greatest improvement in the treatment of psychiatric patients came about with the establishment of psychiatric centers (in certain general hospitals) and of convalescent hospitals in the spring and summer of 1944. By concentrating all closed-ward cases (originating in the Zone of Interior or overseas) in the centers, it was possible to develop active treatment programs which had not been possible in the station hospitals. Under these conditions, shock therapy (mostly electroshock) was used freely for disturbed or agitated psychoses and depressions; subshock insulin treatment was employed in the more severe psychoneurotic reactions with encouraging results; psychotherapy under sedation called narcosynthesis, which had gained great popularity overseas in the treatment of combat neuroses, was resorted to in patients with residual symptoms of psychoneuroses incurred in combat and in cases of conversion hysteria.

CONVALESCENT HOSPITALS

Purpose

In preparation for the large influx of patients from oversea theaters, 13 convalescent hospitals were activated in August 1944. Of these, 12 had large sections devoted to the treatment of mild psychoneuroses. It was originally planned to treat Zone of Interior and oversea open-ward psychiatric cases in the convalescent hospitals—when traditional hospital care was not required. The number of patients who were returned from oversea theaters turned out to be so large that it became necessary to limit the function of the neuropsychiatric sections of the convalescent hospitals to treating oversea cases, with just a few exceptions.

Apart from the need for beds, there were other considerations which prompted the development of the convalescent hospitals. It was generally accepted that the usual type of hospitalization was not conducive to recovery for the average open-ward patient who was not seriously ill.

Symptoms tended to become fixed, patients became somewhat apathetic, and resistance to return to duty gradually increased. ("Hospitalitis" was a term often used to describe this phenomenon.) It was believed that housing patients in barracks, organizing them into company units, and instituting a planned program of treatment and activities would be productive of much better results. At the same time, the concentration of large numbers of patients would result in economies of personnel. Under the supervision of psychiatrists, it was possible to use clinical psychologists and psychiatric social workers for interviewing and observing patients and in group therapy, in addition to their more usual functions. A greatly expanded activities program of education, physical reconditioning and recrea-

tion, occupational therapy, and prevocational training could be justified by the large number of patients.

Organization and Function

The organization of the convalescent hospital was outlined in TB MED 80, issued on 3 August 1944. The neuropsychiatric section constituted just one part of it. In most of these hospitals, the psychiatric patients were organized into their own battalion or regiment but, in at least one hospital, medical, surgical, and neuropsychiatric patients were randomly intermixed without reference to disease category.

The treatment program in the convalescent hospitals, as it ultimately evolved, included scheduled psychotherapy, generally group, from 3 to 5 times a week; occupational therapy, 3 to 5 times a week; and daily physical reconditioning in the form of calisthenics, walks, or gymnasium work coordinated with the recreational activities, such as competitive sports, swimming, fishing, and boating when available.

A daily educational hour was included in which were given such courses as foreign languages, motor mechanics, business administration, agriculture, radio, and typing.

Prevocational training was coordinated with occupational therapy and educational activities in such fields as carpentry, mechanics, metalwork, welding, and radio, and a free period was provided for elective activities such as photography, arts, music, rehearsal for shows, band practice, stamp collecting and other hobbies.[56] A special directive [57] on the use of music in reconditioning emphasized its importance in the treatment of neuropsychiatric patients.

Location

During the peak period of hospitalization, convalescent hospitals, caring for psychoneurotic patients, were established at the following locations:

Camp Edwards Convalescent Hospital, Camp Edwards, Mass.
Camp Upton Convalescent Hospital, Long Island, N.Y.
Fort Story Convalescent Hospital, Fort Story, Va.
Camp Pickett Convalescent Hospital, Camp Pickett, Va.
Welch Convalescent Hospital, Daytona Beach, Fla.
Camp Butner Convalescent Hospital, Camp Butner, N.C.
Camp Atterbury Convalescent Hospital, Camp Atterbury, Ind.
Fort Custer Convalescent Hospital, Fort Custer, Mich.
Fort Logan Convalescent Hospital, Fort Logan, Colo.
Fort Sam Houston Convalescent Hospital, Fort Sam Houston, Tex.
Mitchell Convalescent Hospital, Campo, Calif.
Madigan Convalescent Hospital, Fort Lewis, Wash.

[56] (1) Davis, J. E.: Recreation in the Mental Hospital. Ment. Hyg. 26: 85–91, January 1942. (2) Davis, J. E.: The Importance of Physical Training in a Rehabilitation Program in Mental Hospitals. Psychiatric Quart. (suppl.) 14: 159–167, 1940. (3) Barton, E. E.: Occupational Therapy. *In* Manual of Military Neuropsychiatry. Philadelphia: W. B. Saunders, 1945, p. 604.

[57] War Department Technical Bulletin (TB MED) 187, 26 July 1945.

In some of the convalescent hospitals which had a total bed capacity of 5,000, there were as many as 1,900 psychiatric patients on the roster at one time.

Description of Treatment Program

An excellent description of the operation of the Neuropsychiatric Service of the Percy Jones Convalescent Hospital was given by Lt. Col. Fred F. Senerchia, MC, at a Sixth Service Command Neuropsychiatric Conference held in Chicago, Ill., on 16–17 November 1945. He stated, as follows:

The advent of the convalescent hospital brought into focus many problems. We no longer had wards but companies and battalions. We no longer had ward masters and nurses, but first sergeants, company clerks, duty non-coms, company commanders, and battalion commanders. Since almost all of our patients came directly from overseas, it was necessary to handle these patients at as near a general hospital level as possible if professional standards of care were to be maintained. Therefore, from the beginning we made plans for the rendering of a general hospital type of professional care in a setting of barracks, companies and battalions. To more effectively accomplish this, we had to coordinate the purely administrative services with professional services, so that the two could be welded into an organizational whole and make for a smooth running unit. By borrowing from the experiences of the consultation services and mental hygiene clinics, from the experimental developmental training units set up under the provisions of ASF Circular No. 40, 5 February 1944, and from TB MED 80, we were able to set up such an organization.

Apart from the officer patients, the neuropsychiatric service is organized as a regiment. The regiment is quartered in an excellent area of Fort Custer. The patients are housed in newly reconverted two-storied barracks with a central heating plant and inside latrines and showers. The area has its own Post Exchange, Red Cross Recreation Building, Red Cross Professional Building, occupational therapy shops, conference rooms for orientation and group psychotherapy, athletic fields, and many company dayrooms.

At regimental level are found the regimental commander who is chief of the neuropsychiatric service and the regimental headquarters staff who are the coordinators for the various professional and nonprofessional services rendered the patients from within the regiment. It is also at this level where liaison is maintained with the auxiliary nonregimental services, such as educational and physical reconditioning, separation classification, personal affairs, and the Red Cross. Briefly then, regimental headquarters consists of the commanding officer who is also chief of the neuropsychiatric service, a branch immaterial executive officer who supervises and coordinates the purely administrative functions of the regiment; a chief clinical psychologist who supervises and coordinates the psychologists of the regiment and in addition, maintains liaison with separation-classification and educational and physical reconditioning as operations officer; a chief psychiatric social worker who supervises and coordinates the work of the psychiatric social workers and maintains liaison with personal affairs and the Red Cross; and a sergeant major and clerks.

In order to bring the maximal amount of individualized professional care to the patient, the regiment was organized into five battalions of 400 beds each. Each battalion is headed by a battalion commander who functions, in addition, as its senior psychiatrist. He is the focal point of what is in reality, a self-contained psychiatric unit. He has at Battalion Headquarters level coordinators similar to those at regimental level, namely a branch immaterial executive officer, a chief psychologist, and a chief social service worker. In addition, the Battalion Headquarters or psychiatric

unit is staffed by the company neuropsychiatrists and social service workers, clinical psychologist, clinical records clerks, civilian medical stenographers, and a sergeant major.

The battalion, in turn, is organized into four companies of 100 patients each, comparable to four one-hundred bed wards. Assigned to each company is the company neuropsychiatrist whose duties are comparable to a ward officer even to the making of ward rounds. Assisting him in the discharge of his professional duties are the assigned company social worker and the battalion clinical psychologists. There is thus established a continuous doctor, social worker, psychologist, patient relationship from the moment the patient is admitted to his company or ward until the time the patient is dispositioned. In the diagnosis and treatment of the patient, in addition to the psychiatric team approach and individual and group psychotherapy, the medical officer avails himself of the service of other medical and surgical specialties when the need arises. Also functioning at company level are branch immaterial company commanders, first sergeants, duty noncoms, and company clerks.

The officer section had assigned to it two neuropsychiatrists in addition to a commissioned clinical psychologist. The section was housed in a professional building which it shared with the officer surgical section. The patients were under the administrative control of the commanding officer of the officer patients battalion. This section had a reconditioning program of its own.

The neuropsychiatric service from its inception saw in consultation patients referred from the medical and surgical service. This consultation service was coordinated through the office of the chief of the neuropsychiatric service.

The patients are admitted through the admission and disposition office to the receiving division of the convalescent hospital. There they are examined by a physical examination team, two members of which are neuropsychiatrists. At this level, those cases felt to be too ill for convalescent hospital care are screened out and sent to the neuropsychiatric service of the Percy Jones General Hospital Annex at Fort Custer. In addition to the physical examination, histories are taken and routine laboratory work and chest X-rays are done where necessary. Following this the patients are admitted directly to one of the neuropsychiatric battalions. Here a battalion file is opened on the patient and it is at this level that the neuropsychiatric processing is done by the neuropsychiatrists, psychologists, and psychiatric social workers. In addition to a mental status by the psychiatrist, a psychiatric social summary is obtained by the social worker, and an initial evaluation is made by the psychologist for placement in the educational reconditioning program or for psychometry. When this has been completed and clearance given by the psychiatrist, the patient is ready for furlough if he has come directly from a debarkation hospital. The entire processing from admission to furlough takes an average of less than 5 days. Upon return from furlough, the patient enters the treatment program and is followed up by his company neuropsychiatrist, company social worker, and clinical psychologist. During the course of his treatment the clinical record is completed and when the patient has received maximum hospital benefit, in general between 6–8 weeks after return from furlough, he is brought before a neuropsychiatric staff conference consisting of the battalion commander, who is the senior psychiatrist, the psychiatrist presenting the case and one other medical officer. This staff conference functions also as the disposition board. Here final diagnosis is made, line of duty is established and disposition recommended if it is felt that the patient has received maximum hospital benefit.

Neuropsychiatric Treatment Program: In a discussion of treatment for the convalescent hospital neuropsychiatric patient, in addition to the definitive individual and group psychotherapy, one must include the therapeutic benefits which accrue from the ancillary services. These services include educational and physical reconditioning, occupational therapy, orientation, company commanders discussion hours, individual services, special services, the Red Cross, and the administrative services rendered by the company commanders and cadre. Passes and furloughs are considered therapy.

Every patient, unless specifically excused (usually for an intercurrent illness), is a participant in the daily program which carries on 5 days a week from 0800 until 1630. The morning program in general consists of physical reconditioning, orientation, and group psychotherapy; while the afternoon program consists of educational reconditioning (the school program) or occupational therapy, ward rounds and, weather permitting, a retreat parade once a week. Individual interviews do not follow any set schedule.

Individual Therapy: Because of the excellent facilities offered by the neuropsychiatric section of the Percy Jones General Hospital Annex at Fort Custer, all cases requiring hydrotherapy, Sodium Amytal or pentothal narcosynthesis, insulin therapy or closed ward care were referred to it rather than establish a special treatment section in the convalescent hospital. The more severe cases not requiring the above forms of therapy for proper management were rostered for individual therapy at the Convalescent Hospital level.

At Convalescent Hospital level, the approach was a team approach (psychiatrist, psychologist and psychiatric social worker). The individual therapy given by the nonmedical members of the team was primarily along counseling lines. In general, the individual therapy given by the psychiatrist was not tuned to relieving profound personality problems of longstanding duration, but rather to help the soldier gain insight into the psychosomatic dynamics of his syndrome. Means were offered to ease the symptomatic discomfort by sublimation and rationalization together with straight forward common sense psychiatric orientation.

Group Psychotherapy: Group psychotherapy was conducted for several reasons.

(1) To provide daily contact between the patient and the members of the clinical team which time limitations made impossible on an individual level.

(2) Because there was value in discussion of mutual personal problems on an impersonal group level.

(3) Group discussion made the patient realize that his problem and complaints were not unique but were shared by others.

(4) It allowed for release of aggression.

(5) It gave the clinical team an opportunity to evaluate the total program from the attitude of the group. (Observations obtained by all members of the clinical team were shared for the benefit of the total program.)

Administration: All patients took part in group psychotherapy which was conducted by the psychiatrists, the clinical psychologists, the psychiatric social workers and through the media of selected movies. Groups were conducted on two levels; large group therapy and small group therapy.

Large group therapy was part of the regularly planned program and four 1-hour periods per week were scheduled. The time was divided by all the members of the clinical team. The large groups were company size (maximum 100 patients) and all patients attended large group sessions.

Due to the difficulty of handling large groups and because some patients needed more personalized therapy, small group therapy was given to selected individuals. It was found that the best therapy could be accomplished when the group consisted of 5–10 men, sometimes slightly larger. Patients were selected for small group therapy which was conducted by the clinical psychologist or psychiatrist in different ways: (1) Patients were referred for small group therapy by the psychiatrists and the social workers. (2) Patients were selected by the psychologist and psychiatrist on the basis of the clinical picture which made for a homogeneous group. (3) In one battalion all new patients were handled in small groups. The length of the group sessions usually varied between 45 minutes and 1 hour. No rigid time limit could be set. The meeting was concluded when interest lagged or restlessness was noted.

The atmosphere of the group meetings was informal. Everything possible was done to break down the traditional barrier that existed between officer and enlisted

men. While the therapist had a prearranged plan there was no prearranged text for the meeting. A prearranged text invariably resulted in a health talk which had to be avoided. Occasional straying from the subject caused no great concern. An opportunity for release of aggression was valuable and had to be encouraged.

Educational Reconditioning: Educational reconditioning was considered adjunct therapy. In order to place this activity on a doctor-patient relationship it was coordinated in our battalions through the clinical psychological sections which were under the supervision of the medical officers. As a result, our patients were given assignments by individuals who had understanding of the emotional problems involved and whose progress in the particular studio, shop or classroom was followed from a psychological point of view. The school and shop program aided materially in stimulating a reawakening of interest and combating apathy which was initially present in many of our patients. It helped restore confidence in our anxious patients, particularly those showing preoccupation, restlessness, impaired concentration and inability to sustain attention over long periods of time by proving to them through personal performance, that they could cope with their deficiencies. For those exhibiting "startle reaction," the more noisy shops permitted them to make adjustments to occupational noises.

Occupational Therapy: This was utilized for our more severe anxious patients and those with poor intellectual endowment who were on psychiatric grounds not ready for the more formal school and shop program.

Physical Reconditioning: It was found that maximal therapeutic benefit was derived from competitive games and athletics at inter and intra company, battalion and regimental levels. This approach made for spontaneous participation and, in addition to restoring physical fitness, aroused enthusiasm and a feeling of "belonging" on the part of the patient for the first time since he was lost to his unit overseas and remained lost in the hospital evacuation chain. This rebirth of enthusiasm and feeling of "belonging" made for good patient morale which was essential for effective, more formal psychotherapy.

Special Projects:

Company for Psychopaths: Due to the large number of psychopaths being admitted despite directives, it was imperative that something be done to prevent the undermining of morale of the other patients and sabotaging of the program by these military delinquents. At the suggestion of Maj. Nils B. Hersloff, MC, a special company was activated. This type of patient was processed rapidly and returned to duty to be handled administratively by the line. In time, the company became known as the special treatment platoon to which were sent, in addition to the aggressive psychopaths, those patients who were awaiting courts-martial principally for AWOL and those who were sentenced to restrictions by courts-martial.

Trial Furloughs: When it became apparent that the symptomatology of a small number of patients was aggravated and accentuated by anxieties relative to civilian adjustments and rehabilitation, Major Nils B. Hersloff instituted the policy of trial furloughs. After maximum hospital benefit had been attained and prior to final disposition, this group of patients were given furloughs of from 5 to 10 days. Inasmuch as they were definitely aware of their ultimate disposition, they were enabled to establish their families, obtain employment and accustom themselves to the routine of civilian living. In some instances it was necessary to repeat these furloughs in order to dissipate the accumulated anxiety. Approximately 8 percent of the patients dispositioned by Major Hersloff's board have required and requested such procedure and as a result benefited immeasurably.

Duty Company: The duty company was established at the suggestion of Capt. Willard Z. Kerman after an exhaustive study in order to effect a physical separation between patients who were likely candidates for duty and those who warranted separation from the service. Mingling of duty prospects with those who should be separated

from the service blocked adequate therapeutic endeavors. All duty prospects in the regiment were transferred to this duty company as soon after return from convalescent furlough as possible. At this level orientation and psychotherapy programs were conducted with a return to duty as a key note as opposed to adjustment to civilian life.

This company was of necessity created since the policy of higher authority prevented the medical officers from informing the patient of his ultimate disposition. However, shortly after its establishment this policy was relaxed and the company disbanded.

In a staff evaluation of the program we were unanimously of the opinion that the majority of patients whom we have returned to civilian life have been adjusted to the point where once again they can take their places in the community as useful citizens. There is no single factor responsible for this. The professional approach used, utilizing the psychiatrist, psychologist, and psychiatric social worker as a team was in no small way responsible for the results achieved. While everything done for the patient constituted treatment including company management, the contributions of the professional team in terms of group and individual psychotherapy were the backbone of the treatment program. The therapeutic contributions made in the form of educational and physical reconditioning service were very important adjuncts. We were very fortunate in having at our disposal an unusually fine educational system. The shops, classrooms, and stations were well-equipped and excellently staffed. The agricultural school and its farm was an outstanding project. For the physical reconditioning program we had more than our share of playfields and recreational areas. With the coming of winter there were bowling alleys, new gymnasiums and an indoor swimming pool.

The atmosphere of the convalescent hospital provided an effective framework for the treatment program. The usual hospital ward routine was lacking and in its place was substituted a modified type of garrison living. While it is true that discipline was maintained yet our patients were given considerable freedom. The patient was free to do as he wished after five o'clock and could get weekend passes for the asking providing there had been no breach of discipline. They were in a sense on their own again; and for many of the patients this was so for the first time in many months. The self-imagined stigma of an N.P. ward, even though an open one, had been removed. This simple fact was of untold therapeutic value in that it gave support to damaged egos and restored self-esteem and self-confidence. Most of our patients lived within a distance of 200–300 miles of the hospital, and consequently most of them spent their weekends at home. As a result, many civilian problems surfaced during this period. Fortunately, since the patient was still under military control, he had available the help of his doctor, psychologist, and social worker, who as a team helped him resolve his newly acquired anxieties. This benefited not only the soldier returning to duty, but also the one to be discharged. The latter in essence was being prepared for a return to civilian life. His exposure to it was gradual and controlled rather than abruptly from hospital ward to civilian status.

With this approach we felt that a majority of the patients discharged needed no particular followup in the community. Most of the patients in this group had made plans for the future and many had already secured employment by the time they were ready to be discharged. A small percentage were found however, who although they had received maximum hospital benefit, could profit from further psychiatric followup. Upon discharge these were referred directly by their doctor or through the Red Cross followup service to psychiatric clinics in or near their communities.

We of the Convalescent Hospital staff have always been extremely enthusiastic about the program and its effect on our patients. Since we have no followups, our assessment of the program is based entirely on prognostication by the staff and may for that reason be biased. Be that as it may, we are convinced that the approach used was psychiatrically sound. We shall go one step further and state that for the milder neuropsychiatric casualty, the management of choice is at a convalescent hospital level.

Results

Although each of the convalescent hospitals had psychiatric patients with essentially the same severity of disorders and in the same type of treatment program, there was great variation in the criteria which were used for discharge or return to duty. The disposition of psychiatric cases from 11 hospitals during the period from 11 May to 29 June 1945 was determined from statistical health reports (WD MD Form No. 86ab) which the hospitals submitted to the Office of The Surgeon General. Whereas Welch Convalescent Hospital returned 59.4 percent of its psychiatric patients to duty, Camp Edwards Convalescent Hospital returned only 1.7 percent of its psychiatric patients to duty (table 17).

These results merely emphasize that a medical discharge in itself was no indication of the degree of disability that an individual had upon discharge.

After a visit to the Fort Story Convalescent Hospital, Lt. Col. (later Col.) Henry W. Brosin, MC,[58] Third Service Command neuropsychiatric consultant, reported that 80 percent of the medical discharges during the first 4 months of 1945 were for psychiatric reasons: "Very few of the neuropsychiatric patients have been sent to duty [because] it is difficult to get assignments for these patients. Another hazard is the delay in getting

TABLE 17.—*Disposition of neuropsychiatric cases from convalescent hospitals, 11 May–29 June 1945*

Convalescent hospital	Number returned to duty	Number discharged on certificate of disability	Percent of men returned to duty
Welch, Fla	530	363	59.4
Camp Butner, N.C	169	117	59.1
Fort Sam Houston, Tex	129	737	14.9
Camp Upton, N.Y	143	806	15.1
Camp Carson, Colo	54	520	9.4
Camp Pickett, Va	69	707	8.9
Mitchell, Calif	19	226	7.8
Percy Jones, Mich	85	1,052	7.5
Fort Story, Va	24	507	4.5
Camp Atterbury, Ind	39	1,025	3.7
Camp Edwards, Mass	23	1,299	1.7
Total	1,284	7,359	14.9

NOTE.—Men discharged to duty for administrative discharges may be included in the "duty" figures. Transfers to other hospitals or dispositions other than duty or certificate of disability for discharge have not been included. Percentage of men returned to duty is based only on the "duty" and "certificate of disability for discharge" figures.

[58] Letter, Lt. Col. Henry W. Brosin, MC, 9 May 1945, subject: Report of Neuropsychiatric Consultant's Visit to Convalescent Hospital and Infirmary, Fort Story, Va.

them to a permanent assignment which often vitiates the results of treatment." Colonel Brosin also reported:

> One of the most gratifying aspects of the therapeutic program [at Fort Story] is the prominence given to group therapy and the excellent work which is being done by the medical officers and the MOS 263's [psychiatric social workers]. In addition to the general directions given in TB MED 103, more complex relations are being utilized by the therapists. The more experienced men are able to manipulate the individual expressions of the men so that they have both a general group value and a specific individual meaning. * * * The men are led successively step by step in a coherent fashion to understand their own relations and those of their fellows to authority, to the hospital, to the Army and to the country in a simple straight-forward manner which does much to diminish their tension level. * * * It is estimated that at least 90 percent of the men receive some benefit and that the large majority become reasonably well adapted to the hospital setting with absence of complaints and symptoms. It is noteworthy that the men who retain neurotic action patterns as expressed by undue hostility, guilt, depression, somatic symptoms, passive dependency, etc., have upon examination, deep seated neurotic trends in these directions. It would seem as if the military situation merely gives them an opportunity to exploit previous habit patterns. It might be well for medical officers to examine systematically the thesis that "war neurosis" or "combat reactions" or "fatigue reactions" are caused by adequate exposure to genuine hardship or combat experiences in a relatively stable person with gross acute symptoms which diminish or disappear with treatment.

Maj. Irving L. Turow, MC,[59] reported on his experience with this problem at the Percy Jones General Hospital in Battle Creek, Mich. In reviewing the records of 1,521 neuropsychiatric patients treated at that hospital from February 1943 to September 1945, 1,104, or 73 percent, first manifested emotional symptoms in the Zone of Interior or noncombatant area. The remaining 417, or 27 percent, first manifested acute disabling symptoms in combat. He concluded:

> Although investigation of individual records of the 1104 patients was not thoroughly made, * * * indications are that these patients in the main had neuropathic traits prior to induction into the service. It is not to be assumed that frank neuroses do not occur under Army stress without previous healthy psychiatric history, but the incidence is relatively low.

Turow emphasized the need to differentiate neuroses from neurotic reactions to severe stress.

GROUP PSYCHOTHERAPY

The shortage of psychiatrists and the large number of patients made it impossible to give individual psychotherapy. For this reason, the treatment of patients in groups was encouraged [60] and ultimately widely utilized.

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[59] Turow, I. L.: Neurosis, Neurotic Reaction, and Motivation. *In* Proc. Neuropsychiatric Conference of the Sixth Service Command, Chicago, Ill., 16–17 Nov. 1945, pp. 26–30.

[60] (1) War Department Technical Bulletin (TB MED) 84, 10 Aug. 1944. (2) War Department Technical Bulletin (TB MED) 103, 10 Oct. 1944.

Methodology

Different techniques were developed by the various therapists. In some places, a lecture-discussion method was used, which included series of talks on such subjects as orientation to the hospital, types of nervousness, causes of nervousness, body-mind relations, and the role of dependency, insecurity, and inferiority. In others, a question-answer technique was used. The method most widely adopted was to have patients tell the histories of their illnesses in front of the group and then, to have group discussion of his situation and illness, with some guidance from the therapist. By specific example, it was possible to demonstrate mental mechanisms—the relationship between present symptoms and behavior and emotional patterns which were developed and fixed in childhood. Some therapists undertook analysis of dreams by individuals in front of the group, with good results.

While the early explorations in the use of group psychotherapy tended to be carried on in the general hospital psychiatric centers (for example, Lt. Col. Samuel Paster, MC, at Kennedy General Hospital in Memphis, Tenn., and Maj. Jules V. Coleman, MC, at Lawson General Hospital in Atlanta, Ga.), psychiatrists like Maj. Donald A. Shaskan, MC, utilized group therapy in station hospitals. Some of the most gratifying results were obtained at the Fort Knox Rehabilitation Center where group therapy was included in the daily schedule of activities of the men who were confined there as a result of conviction by general courts-martial. As far as could be determined, this work was begun by Maj. Alexander Wolf, MC, and later developed by Lt. Lloyd W. McCorkle, MC, and his assistants, and by Capt. Joseph Abrahams, MC. Many other psychiatrists throughout the country took part in this early work of using group techniques.

It was recognized in the Neuropsychiatry Consultants Division, SGO, that, if the mass of psychiatric patients were to be treated, they would have to be treated in groups. In planning the convalescent hospitals which later were to treat the majority of soldiers who were returned from overseas because of psychoneurotic disorders, provision was made for group treatment. This was done as much out of necessity as out of the conviction that group treatment had advantages over individual treatment. It was almost a matter of group treatment or no treatment.

Convinced that experience with group therapy was sufficiently successful to warrant its recommendation for widespread use in the Army, TB MED 103, "Group Psychotherapy," was issued on 10 October 1944. The material for this bulletin had been prepared in the Neuropsychiatry Consultants Division to assist most of the psychiatrists who had had little or no experience with this technique. From the time TB MED 103 was issued, increasing use was made of group techniques, and by the end of the war, group therapy was employed in practically every hospital where psychiatric patients were being treated in large numbers.

Dynamic Mechanisms

While the dynamic mechanisms of group treatment were not known, it seemed clear that certain therapeutic forces were operative. The phenomena of group loyalty and group identification were universally observed. Upon the insistence of the group, patients were more apt to regard their behavior objectively than upon the suggestion of a psychiatrist in a private interview. Patients who were concerned solely with their own problems were obliged to consider the group and its problems because of loyalty and fairness which the group demanded. Interestingly, some patients were able to express themselves more easily in a group setting. An occasional therapist believed that some repressed material was verbalized with less difficulty under group therapy conditions.

It has been postulated that the group represents symbolically a family of siblings held together by a common therapeutic need under the guidance of a nonhostile understanding parent. Some therapists have observed patients striving as children to compete with one another for praise and approval, acting out unsolved conflicts of their childhood.

In general, as a result of encouragement by the presence of the group, patients were able to express their hostile aggressive feelings toward the Army and to officers much more easily than would have been possible in individual interviews. This was extremely important since resentment played an important role in so many of the cases the psychiatrists were called upon to treat. Individual patients accepted the group solution to this problem much more quickly than they would have from the psychiatrist who to them was an officer representative of the very thing they were trying to get away from.

In addition, personal problems were minimized and seen in a broad perspective. Guilt feelings concerning failure and incapacity without visible organic disease to justify such failures were partially relieved by the recognition that others had similar disorders. Any insight which was gained by a patient was to a degree available to the entire group.

Airing of symptoms in a group setting helped to demonstrate the universality of individual problems and to relieve feelings of isolation. The need to solve the problem was stimulated by reason of the person's inability to conceal the problem from society any longer. A patient's attitude toward his experiences may be greatly influenced when he observes that the group reaction to it is different from his own; for certain individuals whose difficulties arise from egocentricity and self-indulgence, their obligations to society and need for change can be better emphasized by the group.

Results

It is unfortunate that no carefully controlled study was made, comparing the results of individual and group therapy. The techniques which

were used varied so much, and the personalities of the therapists were so different, that such statistical data, even if available, would be difficult to interpret.

Careful followup studies of the results of group therapy were not possible in the Army for other reasons. One was not dealing with the simple situation of a sick patient seeking treatment. The fact that a patient was returned to duty was no indication that he was well. It merely meant that he was believed well enough to perform duty. On the other hand, when getting well carried with it the secondary gain of a discharge from the Army, as it did in many of the Army hospitals in the United States, a motivating force, such as is not ordinarily present in a psychotherapeutic situation, had to be considered. Then, there were the difficulties of trying to trace a man after discharge from a hospital and of obtaining a reliable and objective report on his condition.

Therefore, the results of group therapy, as it was used in the Army, can be evaluated only in terms of subjective impressions of the men who used this technique and by the relatively few detailed reports which were submitted to the Surgeon General's Office. There was almost unanimous opinion among those who worked with group therapy that it was effective. Many were quite enthusiastic and insisted that group therapy had decided advantages over individual therapy—apart from the economy of time.

It is believed that the Army experience with group psychotherapy has helped confirm the results of the civilians who did the pioneer work in this specialty. This experience should serve as a stimulus to further efforts to perfect and standardize the technique and to clarify its dynamics. Group treatment may be the answer to the need for a more efficient and economical method to cope with the ever-broadening horizon of psychiatry.

FINAL POLICY

Presidential Interest

In December 1944, President Roosevelt expressed some concern about the condition of men upon their discharge from the Army, in the following letter to the Secretary of War:

DECEMBER 4, 1944

My dear Mr. Secretary:

I am deeply concerned over the physical and emotional condition of disabled men returning from the war. I feel, as I am sure you do, that the ultimate ought to be done for them to return them as useful citizens—useful not alone to themselves but to the community.

I wish you would issue instructions to the effect that it should be the responsibility of the military authorities to insure that no overseas casualty is discharged from the armed service until he has received the maximum benefits of hospitalization and convalescent facilities which must include physical and psychological rehabilitation, vocational guidance, pre-vocational training and resocialization.

Very sincerely yours,

(Signed) FRANKLIN D. ROOSEVELT

This letter served to focus the attention of the War Department on what treatment was being given to patients and led to further emphasis of the policy which directed that psychiatric patients be treated.

The Secretary of War sent this reassuring reply to the President:

DECEMBER 20, 1944

My dear Mr. President:

I have received your letter of December 4th concerning the physical and mental condition of disabled men returned from the war. I entirely agree that everything that is humanly possible must be done to return them as useful citizens. In fact, I have made it one of my principal duties when I have been able to get away from Washington to visit the hospitals and rehabilitation centers in order to gain a personal knowledge of what is being done. As you doubtless know, only a portion of this task under our present laws and regulations limiting Army activities falls upon the War Department. A portion of it is handled by the Veterans' Administration.

The War Department since the beginning has followed the principle that no oversea casualty be discharged from the Armed Services until he has received the maximum benefits of hospitalization and convalescent care. The only exceptions are the men who are permanently insane or the tuberculous patients. These men are early transferred to their families or to the Veterans' Administration hospitals for definitive care. Reconditioning, physical, educational and psychological, is begun early during hospitalization and is continued through convalescence. In addition to physical reconditioning, this includes orientation, prevocational guidance and self-teaching courses under the United States Armed Forces Institute, occupational therapy both functional and diversional and recreation. This program is provided for the mentally ill as well as the physically disabled until such time as medical judgment has determined that the expected maximum improvement has been obtained.

Under the present troop strength allotment, the Army cannot undertake pre-vocational trade school training except during that period required for physical or mental treatment of the patient, nor can it indefinitely extend the period of attempted resocialization. Pre-technical training and vocational guidance are provided in the convalescent hospital program now being established.

As you know, under the existing law the Veterans' Administration is charged with the responsibility of vocational training, education, and hospitalization of all discharged service men. The War Department has worked and will continue to coordinate very closely with the Veterans' Administration so that continuity of action may remain assured.

I recently visited several convalescent hospitals in Florida and was much pleased with the care with which reconditioning was being carried on. I also on the same trip witnessed the reorientation which was being given at a redistribution center to unwounded men who were returning on rotation. I deem it of the utmost importance that all of these men, both those disabled and those unwounded who are returning from the long stress of battle experience in the many difficult theaters of this war, should receive such intelligent and faithful care as to not only give them the best possible preparation for their future life but also to completely assure them of their country's interest in their welfare. I enclose several pictures taken during my visit to one of the hospitals in Florida.

I also enclose one of the pamphlets which was given to some of the convalescent patients in the Army hospitals.

Faithfully yours,
/s/ HENRY L. STIMSON,
Secretary of War.

The President
The White House

Secretary Stimson followed up this letter with another, on 28 February 1945:

My Dear Mr. President:

In your letter of December 4, 1944, you expressed concern over the physical and emotional condition of disabled men returning from the war and emphasized that no overseas casualty be discharged from the armed service until he had received the maximum benefits of hospitalization and convalescent facilities.

In addition to the Army program I outlined in my reply of the 20th, comprehensive studies have been made on the subject of psychoneurosis during the past few months both insofar as it affects the soldiers returned from overseas as well as those who have not yet had such service. These studies were conducted by War Department personnel, aided by five of the Nation's outstanding civilian psychiatrists.

Specifically, the field of psychoneurosis insofar as the Army is concerned may be divided into two broad groups. First, those men who entered the Army as normal well integrated individuals whose type of psychoneurosis or maladjustment is a result of military service. The majority of such cases have developed as a result of the severe strains of actual combat. Second, those men who brought with them from civilian life inherent weaknesses such as emotional instability or inadequate personality traits. The majority of these cases appear among the maladjusted, inadaptable and inapt soldiers who cannot qualify physically for oversea service. Both groups include cases ranging from mild to severe, from cases correctible within the means available to a field commander to those requiring hospitalization and the most expert medical treatment.

The soldier who is emotionally sick will, as in the past, receive maximum hospital benefit and treatment. To this end facilities have been enlarged and training provided to increase the medical and other personnel required. In general, the treatment principles are based on well founded experiences gained in this war and in the last, and on sound medical judgment. Every effort is made to treat the combat case early, when treatment is most effective—even within the sound of the guns. As a result a majority of these cases recover and return to full combat duty. Another significant proportion can be salvaged for continued duty in rear areas. Cases that cannot be restored to duty in this manner are returned to the United States where they are treated by special psychiatric techniques which have been found to be both practical and effective. Cases developing in this country are also treated in this manner. No soldier who is emotionally sick will be discharged until every effort has been made toward maximum improvement. When discharge is required it will be through medical channels.

Too often in the past the soldier who is inapt or inadaptable has been classed as a psychoneurotic. Usually this group adjusted fairly well in civil life in spite of their deficiencies, but due to certain mild psychoneurotic tendencies or to an inadequate personality are unable to adapt to military life. Every effort is made through treatment, leadership, education, orientation, motivation and training to enable them to perform satisfactorily, in the military service. Should this not be successful and there is no medical reason for a disability discharge, these men will be released through administrative channels without mention of psychoneurosis.

A related problem is created by those soldiers returned from overseas who find it difficult to readjust to life in the United States. These men are not acutely ill nor do they require hospitalization in the usual sense but their problems are no less real. Here readjustment is a matter of psychiatric treatment, leadership, education, proper motivation, and placement in a job where their ability and training may be constructively utilized. Proper jobs will be provided by shipping overseas all qualified soldiers who have not had such service. In the education and proper motivation phase all

resources will be utilized. By following this procedure we will be able to better prepare these soldiers for their ultimate return to a gainful civil life. Those who are unable to readjust to Army life in the United States will be returned to civil life without the label of psychoneurosis.

It is significant that the general term psychoneurosis will be discontinued in medical records and a more definitive diagnosis used such as anxiety reaction or other accepted term. It is believed the use of such terms will alleviate much of the disadvantage resulting from the overworked term psychoneurosis.

Extensive studies on the subject of psychoneurosis have been made and are continuing in the European Area. Specialists in this field will conduct additional studies in the Pacific Area. These studies are primarily concerned with the preventive phase of the problem.

Knowing your intense interest in the matter, I am forwarding to you this information, as I am confident that the above policies will be of benefit to the soldiers and are in furtherance of your desires.

Respectfully yours,
(sgd) HENRY L. STIMSON,
Secretary of War.

Psychiatric Treatment Made Mandatory

As an outgrowth of this correspondence and a report of the Inspector General's survey of the diagnosis, treatment, and disposition of psychoneurotics, AR 615–361, on medical discharges, was revised (Changes No. 2, 1 March 1945) so that the retention for treatment, on patients with psychoneuroses severe enough to require hospital treatment, was authorized, and it was made clear that other psychiatric cases would receive appropriate treatment while awaiting disposition.

On 28 May 1945, to clarify whatever misunderstanding that still existed regarding treatment (and disposition) and policies (of all patients) The Surgeon General, in a letter to all service commands, stated (regarding psychiatric patients) : "All patients except those with chronic psychoses were to be retained until maximum hospital improvement had been achieved."

Another pertinent directive was issued several months later.[61] It stated: "In no case will individuals with psychoneuroses who are too ill to be at home be discharged from the service and permitted to return home without having been offered the opportunity of further treatment in a Veterans Administration hospital." In addition, individuals with psychoneuroses resulting from oversea service, severe enough to require hospitalization, were not to be discharged from the service until they had reached a point of maximum improvement in a convalescent hospital.[62] This policy was to continue in effect for the duration of the war and the postwar period. It represented a radical change in thought and practice in the Army and was a far cry from the "no treatment and the rapid disposition" days earlier in the war, and it came about not without the

[61] War Department Circular No. 162, 2 June 1945.
[62] Bull. U.S. Army M. Dept. 4: 358, July 1945.

overcoming of much resistance on the part of those who were reluctant to change either their attitudes or methods of treatment of patients with psychiatric disorders.

Conclusion

Criticism was occasionally leveled at The Surgeon General and his staff by civilian psychiatrists for what they considered inadequate treatment of psychiatric patients, but considering the obstacles that had to be overcome, the shortage of trained personnel, and the tremendous load that they had to carry, the accomplishments have been referred to by others as one of the most outstanding of the war.

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CHAPTER XI

General Hospitals

Henry W. Brosin, M.D.

HISTORICAL NOTE

The creation of named general hospitals as permanent installations in the organization of the Army Medical Department is a fascinating story of the long and persistent struggle for improved medical care of patients by means of improvement in standards, training, personnel, equipment, and facilities. The history of this gradual development has been well told in several volumes and need not be reviewed here except as it relates directly to the problems in World War II.[1]

The establishment of permanent-type general hospitals where definitive care was available during time of peace mainly occurred during and after the Spanish-American War.[2] This started a trend, climaxed in 1920 by WD (War Department) General Orders No. 40, issued on 26 July 1920, which placed the named general hospitals directly under the command of The Surgeon General as class II installations. These hospitals were then much freer to grow as professional medical centers with independent budgets and relative freedom from routine field military duties.

DEVELOPMENT OF PHYSICAL FACILITIES

Before Mobilization

One week after Germany invaded Poland, President Franklin Delano Roosevelt proclaimed a "limited national emergency," on 8 September 1939, following which the Congress of the United States and the War Depart-

[1] (1) Ashburn, P. M.: A History of the Medical Department of the United States Army. New York: Houghton Mifflin Co., 1929, pp. 148, 215–217. (2) The Medical Department of the United States Army in the World War. The Surgeon General's Office. Washington: U.S. Government Printing Office, 1929, vol. I, pp. 23–91 and 384–394. (3) Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956. (4) Medical Department, United States Army. Organization and Administration in World War II. Washington: U.S. Government Printing Office, 1963. (5) Preference has been given to references which are easily available to the reader, especially published or potential volumes in the series "Medical Department, United States Army," rather than cite original sources. For a more complete understanding, the reader can now go to these excellent volumes for more data. It is worthwhile for the contemporary student to grasp the fact that the development of the named general hospitals paralleled extraordinary civilian progress and furnished the means for training and maintaining skilled specialists in many departments of various Army hospitals. The notable accomplishments and several unforeseen side effects will be apparent in this chapter.—H.W.B.

[2] The former Army and Navy General Hospital at Hot Springs, Ark., was the smallest and oldest, having been opened on 17 January 1887. This hospital was closed on 30 November 1959.

FIGURE 31.—Neuropsychiatric Section, Walter Reed General Hospital, Washington, D.C., in 1934, before the new extension was built.

ment made plans for mobilization. At this time, the Medical Department of the U.S. Army was operating seven named general hospitals: Walter Reed (fig. 31) at Washington, D.C. (1909); Army and Navy at Hot Springs, Ark. (1887); Fitzsimons at Denver, Colo. (1918); Letterman at San Francisco, Calif. (1899, named in 1911); William Beaumont at El Paso, Tex. (1921); Tripler at Honolulu, T.H. (1898); and Sternberg at Manila, Philippine Islands (1898). In addition, the Station Hospital, Fort Sam Houston, Tex., served a general hospital function for psychiatric patients; later, 4 September 1942, this hospital was designated Brooke General Hospital (fig. 32). These named general hospitals differed from the 104 station hospitals active at that time in that the latter were directed by Army Regulations (AR 40–580, 29 June 1929, and AR 40–590, 2 February 1942) to limit themselves in their medical practice to serve the local community for relatively minor disease and injuries. General hospitals were empowered to receive patients from a much wider area and to provide more complex medical or surgical care, particularly in those specialized fields demanding special training and equipment, such as thoracic, neurological, plastic, or orthopedic surgery.[3]

[3] Army Regulations No. 40–10, 17 Nov. 1941.

FIGURE 32.—Neuropsychiatric Section, Brooke General Hospital, Fort Sam Houston, Tex.

The seven original named general hospitals varied considerably in their bed capacity, personnel, facilities, and equipment.[4] With changing needs, compelled by the progress of the war, this group of general hospitals as well as the 59 which were eventually added often had considerable changes in their mission as determined by the Medical Regulating Unit, controlling admissions, and by ASF (Army Service Forces) administrative policies, particularly regarding methods of discharge.

Mobilization

On 25 September 1940, the War Department authorized the construction of 10 new cantonment-type one-story wooden general hospitals, with a total capacity of 10,000 beds.[5] Considerable delays and difficulties were experienced, however, owing in large part to a lack of clear overall planning at top levels of command. However, during 1941, the following general hospitals of the cantonment type were added: Lovell at Fort Devens, Mass., Tilton at Fort Dix, N.J., Stark at Charleston, S.C., Lawson at Atlanta, Ga., La Garde at New Orleans, La., Billings at Fort Benjamin

[4] (1) Table of Organization 8–507, 25 July 1940. (2) Table of Organization 8–551, 1 Nov. 1940.
[5] Smith, *op. cit.*, p. 19.

Harrison, Ind., O'Reilly at Springfield, Mo., Hoff at Santa Barbara, Calif., and Barnes at Vancouver Barracks, Wash. All of them suffered from various defects in spite of The Surgeon General's insistence that his Office exercise advisory supervision over hospital construction. The basic plans prepared in 1935 were known to be unsatisfactory to the Medical Department in 1940.[6]

The provisions for the care of psychiatric patients were particularly inadequate in both quality and quantity, and this deficit was not totally removed in most cantonment hospitals during the war, thus forcing standards of patients' care to drop below the desired goal of "definitive care" and reducing the expectancy from the "maximum benefit of hospitalization" goal enunciated by President Roosevelt and the War Department. However, psychiatrists were not alone in this unsatisfactory situation, and their problems should be viewed in the total context. This situation has been well described by Smith,[7] as follows:

> Hospitals built on such plans [1941] had sufficient space for some activities and none at all for others. X-ray clinics and laboratories were too small for use in modern medicine. Administration buildings had insufficient space for extensive records required for patients and civilian employees and were cut up into too many small rooms for efficient use. Post dental work required more room than originally expected. General hospitals needed more space for quartermaster activities. Inadequate kitchens and mess storerooms became a source of frequent complaints. Offices for the medical supply officer and the medical detachment commander, recreation buildings for the patients and for nurses, post exchange buildings, ambulance garages, and strong rooms for safeguarding narcotics as required by Federal Law were not included in existing plans. Of equal importance, neuropsychiatric wards for which plans were provided lacked sufficient strength and safety features to prevent patients from attempting escape or suicide.

It is remarkable that most medical officers were sufficiently adaptable to live with these major handicaps and yet make as good a record as they did in the care of patients.

Psychiatric services.—Facilities for the psychiatric patients in the cantonment-type general hospital presented formidable problems in care and treatment, requiring considerable ingenuity and modification to overcome. For example:

> The four W–8 type wards intended for use as closed wards had many defects—the window guards, doors, heating, plumbing, and electrical systems had to be entirely rebuilt. The lock and key system was inadequate. Each ward had as many as thirty (30) different keys which made it necessary to install a master lock and key system. These extensive changes required several months and on 25 October 1941, the first closed ward was in operation.[8]

It is quite understandable that space for various group, recreational, and occupational therapies, including minimal outdoor athletic facilities

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[6] Smith, *op. cit.*, p. 21.

[7] *Ibid.*, pp. 21–22.

[8] Turnbull, Helen D.: History of Tilton General Hospital, Fort Dix, N.J. 1941–46, p. 41. [Official record.]

so that patients could at least get out of doors when the weather was good, was not included. Psychiatrists, in 1935, had just begun to implement on a national basis the large active treatment programs, particularly for acute cases, with numerous skilled assistants from various specialties. Although neuropsychiatric outpatient departments were known in a few university centers, they were not required in most psychiatric hospitals until the war demonstrated their feasibility and value. The goal of preventive medicine to keep patients out of hospitals as much as possible by means of skilled ambulatory treatment was not yet well defined in spite of World War I experience. It does seem unfortunate that the 1941 revisions of the 1935 plans did not reflect these improved medical practices, but rather were a hurried emergency response to the demand for speed and economy. The 1941 revisions were made following numerous complaints from civilian and military sources that these buildings were unsafe from the hazards of fire as well as unsatisfactory for professional and administrative purposes. Expediency, however, dictated policy and operations with little regard for the realities of current medical practices.

Wartime Period

After several painful shifts in policy with regard to meeting the need for hospital beds, the War Department approved, on 6 August 1941, the construction of two-storied semipermanent fire-resistant plants for all future hospitals but, before the plans could be completed, the War Department stopped their use. In December 1941, there were 1,686,403 men in the Army, increasing to 6,993,102 in June 1943, which was the peak of the preparatory period.[9] Obviously, the country at large as well as the War Department and the Medical Department suffered severe transformation phenomena while preparing to send trained men overseas as rapidly as possible. In December 1941, there were 14 general hospitals with 15,533 beds while about 200 station hospitals had 58,736 for a total of 74,269 beds. The general hospitals added 38,226 beds and the station hospitals 161,279 beds, between December 1941 and June 1943. Thus, as of June 1943, there were 53,759 authorized general hospital beds and 220,015 authorized station hospital beds, which seems to be a remarkable achievement in view of all the other competing activities.[10]

Semipermanent-type facilities.—Speed and economy were the prime factors in this new building phase, and simplicity of design was sought above all else. Consequently, the War Department, on 29 December 1941, revoked the previous authorization for the two-storied semipermanent plan in favor of the cantonment type for general hospitals, and a modified theater of operations type of construction for station hospitals. Further reduction in quality was contemplated but not effected, for the latter type

[9] Smith, *op. cit.*, p. 53.
[10] *Ibid.*, p. 68.

of hospital was seen chiefly in AGF (Army Ground Forces) maneuver areas.[11] On 31 December 1941, however, permission to build some two-storied semipermanent plan hospitals was granted if the cost and time involved were not significantly greater. Five general hospitals of this type were finished: Bushnell, Brigham City, Utah; McCloskey, Temple, Tex., Kennedy, Memphis, Tenn.; Valley Forge, Phoenixville, Pa.; and Shick, Clinton, Iowa. There were also five station hospitals of the same type completed during this time. Finding that the initial cost was "considerably greater," the War Department on 16 April 1942 authorized only cantonment-type construction for general hospitals.[12]

Conversion of existing facilities.—Already, in 1940, there had been consideration of the conversion of existing civilian buildings into Army hospitals, but many difficulties prevented either acquisition or conversion of suitable buildings. However, 28 Army hospitals, 23 new and 5 expanded, were established in converted civilian buildings by the end of 1943.[13] Of these 28 hospitals, 10 were general hospitals: Ashford, White Sulphur Springs, W. Va.; Darnall, Danville, Ky.; Deshon, Butler, Pa.; England (later Thomas M. England), Atlantic City, N.J.; Gardiner, Chicago, Ill.; Halloran, Staten Island, N.Y.; Mason, Brentwood, Long Island, N.Y.; Oliver, Augusta, Ga.; Percy Jones, Battle Creek, Mich.; and Torney, Palm Springs, Calif.

Semipermanent, Type A.—During 1942, pressure from the Veterans' Administration to build hospitals which could be converted to postwar use, thereby avoiding another World War I error, and civilian pressure from makers of brick and tile, materials proposed as substitutes for lumber, which was becoming scarce, caused the War Department to authorize a third type of hospital, a one-storied semipermanent type known as Type A. The following 12 hospitals (11 general, 1 regional) of this type were built before the war's end: Battey, Rome, Ga.; Birmingham, Van Nuys, Calif.; Crile, Cleveland, Ohio; Cushing, Framingham, Mass.; DeWitt, Auburn, Calif.; Dibble, Menlo Park, Calif.; Glennan, Okmulgee, Okla.; Madigan, Tacoma, Wash.; Mayo, Galesburg, Ill.; Newton D. Baker, Martinsburg, W. Va.; Northingham, Tuscaloosa, Ala.; and Waltham Regional Hospital, Mass.

During 1943, the Type A hospitals were modified to meet Veterans' Administration postwar needs resulting in the construction of a Type A layout, with five two-storied Veterans' Administration-type buildings substituted for ordinary wards for the McGuire General Hospital, Richmond, Va., and the Vaughan General Hospital, Hines, Ill.

The diversity of facilities called named general hospitals became further apparent when their size was surveyed. The original seven general hospitals were usually about 1,000-bed capacity or less. These capacities

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[11] Smith, *op. cit.*, pp. 68–70.

[12] *Ibid.*, p. 69.

[13] *Ibid.*, p. 73.

were expanded, however, to 1,220 at Army and Navy, 4,000 at William Beaumont, and 3,000 at Walter Reed. World War II hospitals, such as England General Hospital, had a 3,650-bed capacity and Halloran General Hospital, 5,350-bed capacity.

In discussing the neuropsychiatric facilities at these widely varying hospitals, it is apparent that few generalizations will hold: Darnall General Hospital (921 beds) was a State hospital before it was turned over to the Army as a psychiatric hospital, while Deshon (1,774 beds) and Mason (3,032 beds) General Hospitals were converted State hospitals, and all of them were good facilities. The McGuire (1,765 beds) and Vaughan (1,900 beds) General Hospitals likewise were rather good hospitals with satisfactory psychiatric facilities. (All authorized bed capacities quoted here are as of April 1945. *See* Smith, *op. cit.*, pp. 304–311, table 15.)

PERSONNEL

General Considerations

Planning of tables of organization and equipment did not take into account the enormous growth in medical specialization. While psychiatrists wanted trained psychiatric nurses, social workers, clinical psychologists, trained ward attendants with a military occupational specialty number,[14] and recreational and occupational therapists, the other medical services also wanted enlisted men with specialty ratings in several technical branches, as well as civilian dietitians, physical therapy aids, and dental hygienists.

The tables of organization did not provide sufficient men necessary for the job in all categories, including nonmedical officers (branch immaterial), medical officers, and enlisted men, not to mention nurses, psychologists, and social workers, Waacs, and technicians.[15] Even after War Department authorization for higher quotas of qualified men and women, such personnel were seldom available in sufficient numbers. It should be remembered that there was considerable civilian pressure against "aggressive Army recruitment" which was applied by powerful voices in Congress (special subcommittee of the Senate Committee on Education and Labor), by the Office of Civilian Defense, and by the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians of the War Manpower Commission.[16] The results of these and other pressures for officers and enlisted men overseas resulted in relatively smaller medical staffs with larger civilian components and Waacs, and with some increase in social

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[14] Later, Neuropsychiatric Technician SSN 1409 by authority of War Department Circular No. 209, 13 July 1946.

[15] Smith, *op. cit.*, pp. 131–137.

[16] Medical Department, United States Army. Organization and Administration in World War II, pp. 146–147.

and recreational workers, clinical psychologists, and other specialists, especially MAC (Medical Administrative Corps) officers.[17]

Neuropsychiatrists

Since there were so few Regular Army psychiatrists in 1939–40, and most of these were assigned administrative duties, the new general hospitals, opened in 1941, were largely staffed by newly inducted civilian psychiatrists, often chosen from the lists provided by the American Psychiatric Association or the National Research Council (p. 42).

Lt. Col. (later Col.) Arthur B. Welsh, MC, in the Surgeon General's Office, did an excellent job in choosing highly qualified men in all medical specialties from civilian life who also were able to meet the manifold demands of the new and strange military life. With very few exceptions, the early staffing of the new general hospitals upheld the traditional goal of the Medical Department to provide "definitive care" comparable to that of the best civilian hospitals. The newly inducted psychiatrists in general hospitals too often met inadequate physical facilities, personnel, and equipment to do the work which poured in from the beginning of the active mobilization in November 1940. It is curious to reflect that almost all Regular Army medical officers in the field that this author met agreed, during this pre-Pearl Harbor period, that the neuropsychiatric problem would be the major medical problem of the war and consequently should be given much support, but apparently this attitude did not prevail in higher command circles, in spite of the obvious experience of past wars.

The attitude of medical and line officers during this period and throughout much of the war if they did have a psychiatrist was often "I have no use for psychiatry but we like our psychiatrist." In the new one-storied wooden cantonment hospitals, the psychiatrist was usually given willing support by his commanding officer, insofar as he was able, to buttress the walls which had been smashed, shield windows with heavier screens, obtain more substantial doors and locks, cover the pipes on the ceiling to forestall hanging, and otherwise protect the electrical and heating systems in the wards for acutely psychotic patients. In time, as the workload increased and treatment and disposition measures became clearer to all concerned, most psychiatrists in general hospitals earned the sincere help of their superiors. As in the field, much of the administrative and repair work done during 1941–42 was done on the personal initiative of the psychiatrist and the commanding officer or his representative on a "learn as you work" or impromptu basis without tutoring from above.

The number of neuropsychiatrists assigned to a general hospital was never large. In most 1,500–2,000-bed general hospitals, there were usually two or three "trained" men with one or two young assistants on "perma-

[17] Smith, *op. cit.*, pp. 131–137.

nent" assignment, during the 1941–45 period. Larger general hospitals had proportionately larger staffs, but they were seldom opulent for more than a few weeks at a time even when newly inducted medical officers were assigned for temporary periods of training while awaiting transfer to their permanent posts, or when a numbered station or general hospital was in the vicinity for training. The total number of psychiatrists with various levels (I–IV) of training assigned to general hospitals at any given date was not easily available from existing records, but an approximation would be 285 on V–E Day (8 May 1945) of 1,012 in the Army Service Forces or of a total 1,515 in the Zone of Interior.[18]

Some highly qualified psychiatrists were assigned to general hospitals, but ofttimes their experience, skills, and leadership were lost to the Army. This was often obvious in general hospitals when the chief of psychiatry was usually junior to the chiefs of other services. During the summer of 1943, this situation was improved when the status of an independent psychiatric service was granted. Professional staffing, however, was not so easily remedied [19] as young, relatively untrained psychiatrists constituted over half of the psychiatric staff of the general hospital. Of necessity, these young men were required to assume numerous responsibilities for which they were not professionally equipped.

Nurses

There were relatively few nurses trained in psychiatry in civilian life in 1940, and this lack was most evident in the Army. Even though there were nearly 600 women trained for neuropsychiatric duty in the Army, there was no official recognition of their special skills, and many of them were assigned to other fields of nursing.[20] Most general hospitals were pleased to have even one trained psychiatric nurse, and welcomed anyone who had some experience or who showed an interest in the work where she received on-the-job training. If the usual 150- to 250-bed neuropsychiatric section had two or three nurses with experience in psychiatric or neurological nursing, they considered themselves fortunate. Even during 1942–43, before there were large troop movements overseas, there were relatively few trained psychiatric nurses unless there were field units in training nearby. For a better picture of nursing activities, the reader is referred to the chapter on this subject, but tribute should be paid to these women who worked so loyally under many handicaps.

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[18] For total numbers of psychiatrists in the Army, and their classifications, see chapter III, p. 48.

[19] Farrell and Berlien, in their chapter, "Professional Personnel," summarize the acute shortage of psychiatrists and the various steps taken to counteract it.

[20] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 247.

Clinical Psychologists

The full history of the development of clinical psychologists is contained in the chapter on that subject and need only be touched upon here.[21] Clinical psychologists were welcomed by general hospital psychiatrists because they were able to help in the daily clinical load; also, they were able to help with special diagnostic and evaluation tests. Following the precedent established in World War I when clinical psychologists were commissioned in the Sanitary Corps (after the war they were transferred to the Office of The Adjutant General), six clinical psychologists were again commissioned in the Sanitary Corps and assigned to work in the general hospitals [22] with psychiatrists. Some enlisted men worked as psychologists, MOS (military occupational specialty) 289, but there was no official approval of their assignment.[23] Later, in 1944, a reorganization of these activities by Dr. Walter V. Bingham and Lt. Col. Morton A. Seidenfeld, AGD, resulted in commissioning as second lieutenants, 244 men under The Adjutant General. War Department Technical Bulletin (TB MED) 115, which described the functions of clinical psychologists, was issued on 14 November 1944. The clinical psychologists were later transferred to the Medical Administrative Corps [24] to enable them to identify with medicine. They were of enormous help in the general hospitals where they worked as an integral part of the clinical staff.[25] Unfortunately, most general hospitals did not have their aid until late 1944 or 1945.

Psychiatric Social Workers

For reasons not immediately obvious, administrative as well as practical considerations delayed the procurement and proper professional utilization of psychiatric social workers, despite their well-established place on the civilian psychiatric team. In October 1943, belated recognition occurred in creating MOS 263 for enlisted men, and in 1944, the Women's Army Corps recruited both social workers and psychiatric assistants. Commissions were not approved for social workers until after V–J Day (TM 12–406, February 1946), although about 50 qualified social workers who could meet basic requirements were commissioned as psychologists in order to bring in at least a few members of this category of critically needed specialists. There were 711 men and women with an MOS 263 or equivalent classification, during August 1945, but this number was not sufficient to fill the need for social workers. Even many general hospitals did not have one until late in the war because of the critical need in con-

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[21] The Medical Department of the United States Army in the World War. The Surgeon General's Office, 1929, pp. 395–405.

[22] At Darnall, Fitzsimons, Lawson, Letterman, McCloskey, and Walter Reed General Hospitals.—A. J. G.

[23] Menninger, *op. cit.*, p. 244.

[24] War Department Circular No. 264, 1 Sept. 1945.

[25] Menninger, *op. cit.*, p. 245.

sultation services, disciplinary barracks, and rehabilitation and redistribution centers. There is no doubt that where present they were valuable members of the psychiatric team.[26]

Psychiatric Attendants

Almost all neuropsychiatric sections in general hospitals gave didactic and informal instruction to ward attendants from the beginning of the mobilization because of the lack of trained men and the absence of any recognized position or training for them. To begin with, there was no selection as such, or in one sense there was even a powerful negative selection in some general hospitals, where enlisted men could not be easily transferred to or from field units. One example illustrates a widespread problem, particularly during the early years of the war. When the commanding officer of a newly opened general hospital surveyed the cadre of enlisted men who had been sent to him from a training center, he found a few intelligent, reliable NCO (noncommissioned) officers and some NCO's of marginal ability, but most of the men were of questionable ability in any specialty. Upon questioning, it was found that undesirable men, including a considerable number for the guardhouse, had been ordered for transfer to the general hospital as one method of disposition. The better men were needed in such responsible positions as surgical assistants, assistants in X-ray and anesthesia, and recordkeeping, while those in the next category of competence were assigned to the medical and surgical wards needing help with the acutely ill. The least competent found their way to the kitchen and police details and the psychiatric wards.

Psychiatrists and nurses were forced to work overtime and to exercise constant supervision over these unrestrained, semiliterate men to minimize their crude, aggressive attitudes toward patients. Sooner or later, these men eliminated themselves by AWOL (absent without leave), alcoholism, and even assault and robbery, but their replacements were usually also men of marginal ability. Owing to the wartime pressure to utilize all available manpower, it was difficult to correct this situation. The few industrious and loyal attendants who worked overtime to do the necessary work were vulnerable to transfer, and during the early years, all of them were transferred to cadres of numbered station and general hospitals. Not until experienced psychiatric attendants were given recognition and their duty stabilized was there some correction of this unsatisfactory situation; this was described by Menninger,[27] as follows:

> After much persuasion a directive [ASF Circular No. 310, 16 Sept. 1944] was published in September, 1944, which allowed the modification of the specialty number of "medical technician" by placing NP after the number 409, on the records of attendants with psychiatric training and experience. After that, except

[26] Menninger, *op. cit.*, pp. 245–247.

[27] *Ibid.*, p. 247.

under unusual circumstances, these persons could not be taken out of the type of work [War Department Circular No. 209, 13 July 1946, finally established the military occupational specialty "neuropsychiatric technician (SSN 1409)" pending revision of TM 12–427, 12 July 1944] for which they had qualified.

Ancillary Service Personnel

Medical administrative officers

Medical administrative officers were important to the general hospital system because they were given increasing responsibility as the war went on to relieve medical officers of nonprofessional duties. One general hospital (Tilton) had a total of 85 such officers, including branch immaterial officers, at the peakload. In the large psychiatric centers, they were highly valued colleagues, but they were not available to most of the smaller neuropsychiatric services during the war.[28]

Women's Army Corps

One of the ways to fight the manpower shortage was the creation of the WAC (Women's Army Corps), in July 1943, formerly an auxiliary unit known as the Women's Army Auxiliary Corps. While Wacs were assigned to many general hospitals, no overall information is available about their activities in neuropsychiatric services. This author does not recall any Wacs being trained as psychiatric assistants, although they were often admirable workers as clerks, administrative assistants, mess attendants, and drivers.[29]

The American Red Cross

The accomplishments of the American Red Cross are well known. Their quasi-official relation to the Army (called affiliation), apparently based upon traditional relations, gave them status and a well-defined position in the Army, particularly in hospitals. There were "3,853 (31 October 1945) in the United States affiliated with the Medical Department. Nearly 9,000 women were employed in the many other Red Cross activities throughout the Army." [30] Psychiatrists in general hospitals were often entirely dependent upon the Red Cross for social workers and recreational therapists, along with trained leaders in social activities, which were important in treatment programs. There were too many local variations in assignments and duties to make many generalizations but, during the first 2 years, these women did valuable service wherever they were assigned.

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[28] Smith, *op. cit.*, charts 2, 3, 6, 12, 13, 15, and 16.

[29] Mention has been made that, in 1944, Wacs were recruited as social workers and psychiatric assistants. At Fort Hood, Tex., Station Hospital, two Wacs worked on the neuropsychiatric service in 1945–46 as clinical psychology technicians and did a very commendable job. See also chapter X.—R. J. B.

[30] Menninger, *op. cit.*, p. 116.

During this early period, volunteer workers were often useful in writing letters of inquiry to relatives but the quality of work was uneven. The Gray Lady units which were developed to a high level of excellence in many general hospitals, during 1943–45, often were helpful with psychiatric patients.

Clerical workers

For psychiatrists who had a great deal of paperwork (correspondence, preparation of various administrative and medical reports, and the like), the quality of clerical help was of crucial importance. Good clerk-typists and stenographers were eagerly sought and highly prized, but competition with better paid jobs in business and industry did not make recruiting easy. In general, many medical officers will attest to the faithful service of many dedicated women who worked as hard as they could.

Occupational therapists

There were about 900 occupational therapists in the Army who were never commissioned [31] although they were often an essential and integral part of the treatment program. All general hospitals had them as nearly as can be determined (see also ch. XXII, "Occupational Therapy").

Volunteers

Civilian volunteers of various categories, including Red Cross aids, Gray Ladies, church groups, and clubs, played an active part in the treatment program of some general hospitals. In one general hospital (La Garde), a highly developed group music therapy program was developed by a teacher of music. Librarians, sometimes paid, but also those who volunteered, deserve commendation. Representatives of all religious faiths lent their support, rarely as a part of scheduled activities, except that attendance at chapel was encouraged. Recreational therapists as such were not recognized in general hospitals until the large reconditioning and rehabilitation programs were instituted. They were not as prominent a part of the neuropsychiatric treatment program in most of the general hospitals as they were in the convalescent hospitals.

Summary

To summarize this personnel discussion as it relates to the manning of the general hospitals, reference is made to the following statement made by Smith: [32]

[31] Commissions were authorized by the Army-Navy Nurse Act of 1947.
[32] Smith, *op. cit.*, p. 259.

* * * during the earliest part of the war Army hospitals had larger staffs than they actually needed to maintain a satisfactory standard of care, for the Surgeon General's Office itself was agreeable to some reductions in 1944 when necessity required them.

It is probable that, from the overall national or Army-wide point of view, this statement is correct for the reasons given by Smith, but this does not take into account the genuine hardships endured by many medical officers who carried clinical and administrative duties far beyond any reasonable expectation because of faulty distribution and assignments. Smith's careful documentation of the conflicts and confusion brought about by lack of adequate planning and delineation of authority and responsibility can be used as evidence for some of the areas of short supply, as in neuropsychiatry. This conclusion also fails to take into consideration his own thesis, with which this author agrees, that lack of planning also resulted in faulty use of men during training periods and after, so that, while there may have been an adequate number of medical officers in the total Army during 1941–42, they were not available for clinical work in many of the most active hospitals. In fairness to Smith, it should be added that he also cites the opinion of some medical officers, including some service command surgeons and the chief of The Surgeon General's Hospital Division, who "believed that medical care suffered as a result of changes in both the quality and quantity of personnel changes assigned to hospital staffs." [33]

POLICIES AND CONFLICTS

For a proper appreciation and broad understanding of the problems encountered in the evolution and growth of Army general hospitals during World War II, it is necessary to review some of the leading controversial issues which caused much conflict and fluctuation of policy both within the Surgeon General's Office and between the Surgeon General's Office and other branches of the War Department, particularly the Hospitalization and Evacuation Branch of the SOS (Services of Supply, later renamed Army Service Forces in 1943). These issues with particular reference to neuropsychiatric care and treatment were as follows:

1. The economical use of building material and other supplies, even though this resulted in inferior construction which proved equally expensive in the long run.[34]

2. The conservation of manpower, both civilian and military, resulting in understaffing in all categories in most of the neuropsychiatric installations except for brief periods.

3. The urgency of constructing and expanding medical facilities to obtain needed medical beds for the rapidly expanding Army, and the need

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[33] Smith, *op. cit.*, p. 260.

[34] *Ibid.*, pp. 13–26.

to obtain priorities in competition with other essential activities, encouraged the continued use of the patently inadequate 1935 plans or the inadequate 1941 revision even though their defects were well known.[35]

4. The use of simplified administrative methods of either returning men to duty or separating them from the service expeditiously in order to free hospital beds for those who needed them most. The pressure to free beds was a matter of grave concern to higher Government officials including President Roosevelt and Secretary of War, Henry L. Stimson, and this was reflected in the fluctuations in policy.

5. The strong desire to standardize all hospital building, facilities, equipment, and personnel practices in order to simplify administration conflicted with the obvious fact that the medical requirements for hospital beds vary considerably from time to time and that medical services are distinctive functions which can operate best where the local commanding officer has some margin for exercising his ingenuity and judgment.

6. The conflicting goals of retaining manpower in the Army at all costs when the war effort seemed to demand it versus the liberal policy of permitting, and even encouraging, the use of the CDD (certificate of disability for discharge) to control the size of the Army when the tactical situation changed were reflected in ambiguous or even contradictory directives by the War Department.

7. The disagreement about assignments for professional men and the failure to utilize special skills properly.

8. The disagreement about the methods and value of reclassification, reassignment, and the limited-duty concept.

9. The disagreement about the meaning of "maximum hospitalization" and treatment, particularly in several surgical specialties and in neuropsychiatry.

10. The lack of adequate means of returning psychotic patients during the early years of 1941–43 to a hospital near their homes.

11. The lack of agreement about the definition of "mental illness" as a cause for hospitalization and discharge which did not reach reasonable solution until 1944.

12. The lack of adequate delineation of the responsibility and authority of the Surgeon General's Office following the reorganization of the War Department in March 1942, when three new major commands (Army Air Forces, Army Ground Forces, and Services of Supply (Army Service Forces)) were created to operate in the Zone of Interior. The Services of Supply was responsible to the General Staff for the corps areas and the technical and supply services, such as the Medical Department and the Quartermaster Corps, together with some administration and personnel functions. In the new organization, The Surgeon General was merely an adviser to the Commanding General, SOS, Maj. Gen. (later Gen.) Brehon B. Somervell, and the extent to which he could discharge his responsibilities

[35] Smith *op. cit.*, pp. 13-37.

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depended primarily upon the degree to which General Somervell accepted his recommendations relative to (1) SOS medical matters as the basis for command decisions and (2) Army-wide medical matters as a basis for action or advice to the Chief of Staff. So far as hospitalization and evacuation in particular were concerned, it depended—partially, at least—upon the role of a medical section in SOS headquarters.[36]

Role of the Surgeon General's Office

In general, the Services of Supply favored decentralization in many areas while the Surgeon General's Office favored more central control. While there were no spectacular resolutions, even after the Wadhams Committee [37] final report which had been submitted on 24 November 1942, The Surgeon General, during 1944, was gradually able to regain many of his former responsibilities as a staff officer to the General Staff. This progress culminated, apparently with the help of civilian pressure, in WD Circular No. 120, issued on 18 April 1945, with the reassertion of the principle that The Surgeon General was the chief medical officer of the Army and the chief adviser to the Chief of Staff and the War Department, particularly on health matters of an Army-wide scope.[38]

By the time the war was over, The Surgeon General had won back most of the responsibilities of this office which had prevailed before the March 1942 reorganization. It is worthwhile noting that the Ground Forces Surgeon (Col. (later Brig. Gen.) Frederick A. Blesse, MC) had equal status with The Surgeon General, but worked in harmony with the Surgeon General's Office. The Chief of the Medical Division of the Inspector General's Office, Brig. Gen. (later Maj. Gen.) Howard McC. Snyder, as a member of the War Department Special Staff, was actually on a higher level, yet "no serious friction developed." These men never took a position that they were entitled to a medical service independent of the Surgeon General's Office, as did apparently the Hospitalization and Evacuation Branch, ASF, and the Medical Division of the AAF (Army Air Forces). It is interesting to note that, while the original members of the Hospitalization and Evacuation Branch insisted that they were the superior agency to which The Surgeon General must report and defer, their successors reversed this opinion and reduced the branch to a section in April 1943, removed its operational functions entirely in November 1943, and abolished it in February 1944.[39] This occurred after Col. (later Brig. Gen.) Robert C. McDonald, MC, had come into this office (6 February

[36] Smith, *op. cit.*, p. 55.

[37] The Wadhams Committee was a civilian committee appointed by the Secretary of War in September 1942 to make a thorough survey of professional, administrative, and supply practices of the Medical Department. Although it called itself the Committee to Study the Medical Department, it became better known as the Wadhams Committee from the name of its chairman, Col. Sanford Wadhams, MC, USA (Ret.).

[38] Medical Department, United States Army. Organization and Administration in World War II, p. 329.

[39] Smith, *op. cit.*, pp. 159 and 172.

1943). Colonel McDonald was able to negotiate with the new Surgeon General, Maj. Gen. Norman T. Kirk, who had been appointed on 1 June 1943, without difficulty.

These early circumstances of lessened control by The Surgeon General helped compound the normal difficulties and delayed smooth operation of the general hospital system for several years. Taken all together, these issues furnish a colorful background for the confusion which existed over some of the medical policies and operations until 1945. It would be a mistake to try to visualize the activities of an abstract typical general hospital. In spite of some similarities in organization and function, if not in location, size, and facilities, the differences in mission together with the wide variation in operations in response to the many pressures mentioned resulted in widely varying practices at many levels of administration, medical treatment, and disposition, often reflecting the energy, ingenuity, and bias of the local hospital commanders and their staffs.

In spite of these handicaps, however, the philosophy of the general hospital system in the Zone of Interior seemed sound, causing the War Department to authorize the ratio of general-hospital type beds to the total strength of the Army to be 1 percent. Total hospital beds authorized was 4 percent of troop strength. Eventually, there were 61 named general hospitals, 4 camp general hospitals, 1 prisoner-of-war general hospital.[40] The changes in bed capacity of the hospitals due to various wartime needs from 1941–46 are too numerous to follow in detail, but several large trends, such as mergers of adjacent station hospitals with general hospitals, use of general hospitals as receiving, embarkation, and debarkation centers, designation of special treatment centers, and growth of regional and convalescent hospitals, will be discussed later. At this time, it is important to point out that after the war was over and special needs disappeared, the named general hospital system, having proved its worth, was stronger than ever and continued to be the backbone of the professional medical work.

Summary

In retrospect, it can be stated that there were many complex pressures and motivations in conflict at many steps of the process of building sufficient hospital beds for Zone of Interior troops, and many changes in plans, until the actual changes in the war overseas eliminated the need for more building. Some of the differences of opinion between the various branches of the War Department were never reconciled. While such conflicts were inevitable, and even necessary at times, it seems that many of the disputes following the reorganization of the War Department in March 1942, with the steadily diminishing authority and responsibility of The Surgeon General for the health of troops and care of the sick and wounded, could probably have been obviated with better mutual understanding.

[40] Smith, *op. cit.*, pp. 304–313.

FUNCTIONS AND OPERATIONS

General Considerations

In the preceding descriptions of some of the phases of the organization and administration of the Medical Department which affected the operations of the general hospitals in the Zone of Interior, and in the survey of facilities and personnel, there are both explicit and implicit data and interpretation regarding the operation of these hospitals. The basic concept of a general hospital system was, and is, a sound one, and the prewar and postwar organization and administration were, and are, apparently satisfactory for peacetime needs. Wartime needs altered the actual working goals and functions considerably so that it is doubtful if any 3 of the 65 general hospitals (plus 1 prisoner-of-war hospital) were really similar in most of their activities for the entire war period. As special urgent missions diminished or disappeared, general hospital functions and methods of operation became less idiosyncratic and more uniform in consonance with the growing body of explicit directives from the War Department and the Surgeon General's Office. All officers serving in general hospitals, during 1941–43, will recall the repeated, and often heated, consultations with command and colleagues about the meaning of existing regulations in terms of new directives and the realities of the local situation. Telephonic or letter requests to service command headquarters for clarification were not infrequent during periods of transition. Even at higher echelons, reinterpretations or reversals of judgments were not unknown within a 48- to 72-hour period. Consequently, any relatively condensed statement about operations will necessarily be overly simplified, but it is the hope of the author and the editor that these will not be misleading.

Tables of organization indicated the conventional chain of command and the number of persons assigned to the new general hospitals. However, there were no standard "manning tables" for the original seven general hospitals, nor was there any standard guide beyond an old Army regulation (AR 40–590, 21 November 1935) which "gave hospital commanders much discretion in both fields [organization and administration] and lacked detailed instructions for inexperienced officers to follow." [41] To meet the foregoing immediate need for reliable information, an entire issue of the *Army Medical Bulletin* of October 1940 carried an article on the subject of organization and administration. This article was revised and issued as WD Technical Manual 8–260, in July 1941.[42]

Perhaps the single most important factor which increased decentralization and uniformity, with patent advantages and disadvantages, was, in 1942, the placing of all general hospitals except Walter Reed under service

[41] Smith, *op. cit.*, p. 26.
[42] *Ibid.*

command control. These hospitals remained under such command until 18 April 1945 when WD Circular Letter No. 120 restored them to the control of The Surgeon General; also restored were some of The Surgeon General's pre-1941 responsibilities. The lack of planning discussed earlier, and the lack of adequate information available at any level as problems arose, caused many conflicts and attendant delays.

Psychiatric Services

Except in a few general hospitals, where there were larger psychiatric services, neuropsychiatry during 1941–43 was a section of the medical service. In most of the general hospitals, the neuropsychiatric section was either too large or too active to permit close personal supervision of individual cases, although the chief of the medical service and the commanding officer usually participated actively in the interpretation of regulations, making decisions regarding LD (line of duty), and reviewing unusual cases, particularly those involving the retirement of officers. During 1942–43, many psychiatric sections were given independent status as a service by general agreement.

In addition to the large inpatient population, most general hospitals had a large consultation service both for soldiers and for their dependents.

Many general hospitals housed prisoners in the closed wards, but this was specifically prohibited after June 1944.[43] Local usage varied about sending alcohol addicts and prisoners for psychiatric examination preliminary to court-martial, but this was not the major problem in general hospitals. It was a problem in some station and regional hospitals where the intensive preparatory work and the time lost while at the trial took a medical officer away from other urgent duties.

Psychiatrists were also required to write a report when enlisted personnel were subject to the Army "Sanity Board" (AR 600–500) and to the board proceedings preliminary to administrative discharge for lack of adaptability, inaptitude or undesirable habits or traits of character, enuresis, or homosexuality. During 1941, psychiatrists were sometimes asked to appear personally but, later, this duty was frequently waived because of the time consumed. Ordinarily, this was a small percentage of the total clinical load in general hospitals.

Training obligations to all components, medical officers, nurses, ward attendants, psychologists, social workers, and specialists in various types of group therapy were constant duties throughout the war in most general hospitals. The chapter on training and references to these activities in other chapters will give the reader a broader view of the psychiatrist's activities in helping his colleagues become effective members of his team.

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[43] Letter, The Surgeon General, to Commanding General, ASF, and Commanding Generals, all service commands, 6 June 1944, subject: Confinement and Assignment of Personnel to the NP Sections for Disciplinary Purposes.

When general hospitals had a large pool of medical officers or nurses, formal didactic courses were given, as well as on-the-job training.

This brief review does not include the many other activities of psychiatrists, such as advising their commanding officers in numerous matters not directly related to psychiatry; being responsible for the transportation of psychotics; holding informal consultations with field officers; maintaining liaison with visitors from service command headquarters and the Surgeon General's Office; and establishing working relations with the service command consultant who was usually looked to for information, interpretations, and direct help when local resources seemed inadequate. A word of commendation should be said also for the local civilian neurologists and neurosurgeons who, when available, were often a great help in difficult diagnostic or therapeutic cases.

Mission

The historic mission of the general hospitals was to provide definitive care to the sick and injured patients transferred from other posts and station hospitals over a wide area. By virtue of having trained specialists and adequate equipment to provide treatment for the more obscure and difficult patients, the general hospitals were given this major mission, but a number of general hospitals also acquired other functions, as necessitated by local needs. For general hospitals near ports, one such function was the acceptance of soldiers in embarkation or debarkation when other facilities were not available, and "during the emergency period he [The Surgeon General] had used general hospitals near ports—Tilton for New York, Stark for Charleston, La Garde for New Orleans, and Letterman for San Francisco—to receive and care for patients brought in on ships." [44] Many of such patients were disturbed neuropsychiatric cases requiring much emergency help. If the number of neuropsychiatric cases was too large to absorb, preparations for their transfer inland were carried out, usually with unexpected efficiency. The practice of granting bed credits to ports continued during the war until the Medical Regulating Unit, SGO, was established in May 1944, when better control of beds became possible.[45]

Some general hospitals acted as the receiving hospital for as many as 12 varied installations, many of them sending in emergency cases. This meant that general hospitals could not keep patients for definitive care, particularly if this required prolonged hospitalization, nor were sufficiently skilled experts in all fields available in all general hospitals to provide such care. The daily pressure for beds was growing during 1942, and more of the best medical specialists in the Army were going overseas. Consequently, following preliminary planning during 1942, the Surgeon General's Office, in March 1943, designated some general hospitals as centers

[44] Smith, *op. cit.*, p. 114.
[45] *Ibid.*, p. 180.

for specialized treatment.[46] Only gradually, as the war situation stabilized and more beds became available in the Zone of Interior was there a possibility for conducting more consistent, sustained treatment programs. Gradually, 26 of the 65 general hospitals were designated as neuropsychiatric centers. Darnall General Hospital opened in March 1942 as an exclusive neuropsychiatric center, receiving only emotionally disturbed (psychotic) patients. Mason General Hospital opened in July 1943 as an exclusive psychiatric center. (As of April 1945, the authorized bed capacity was 921 for Darnall General Hospital and 3,032 for Mason General Hospital, as already mentioned (p. 303).) The volume and character of the patients varied with tactical needs in the other hospitals.

Patient Workload

For much of the first 2 years of the war, the number of patients treated in general hospitals in the Zone of Interior was undoubtedly smaller than the number cared for in station and regional hospitals. The ratio, however, changed sharply as troops moved overseas and with the addition, in 1943, of 24 new named general hospitals.

During December 1941, general hospitals had approximately 10,000 beds available with over 80 percent occupancy, and station hospitals had approximately 58,000 beds with perhaps 40,000 occupancy. In June 1943, general hospitals had about 48,000 available beds with approximately 33,000 occupancy. For this same period, station hospitals reported about 175,000 beds available, with about 135,000 beds occupied. For the period June 1944–December 1946, the following hospital data[47] indicate the magnitude of service rendered in general hospitals as compared with station, regional, and convalescent hospitals:

As of June 1945, general hospitals had 152,971 authorized beds with 81.4 percent occupancy, whereas station hospitals (both AAF and ASF) had 51,561 beds with 67.1 percent occupancy; regional hospitals (both AAF and ASF) had 50,078 beds with 73.4 percent occupancy; and convalescent hospitals (both AAF and ASF) numbered 59,978 beds of which the AAF had 11,600 beds with 47.7 percent occupancy and the ASF had 48,378 beds with 74.8 percent occupancy. In short, the general hospitals had almost half of the total number of beds (314,588) with the highest bed occupancy and the highest number of patients reported per 100 beds, namely 122; whereas AAF station hospitals reported 55 patients per 100 beds and ASF station hospitals reported 77 patients per 100 beds. This huge increase in general hospital patient load came relatively late in the war as 10 new hospitals were activated in 1944 and 4 in 1945.

The influence of the general hospitals, however, extended far beyond their patient population, because they were the models which were emu-

[46] (1) Smith, *op. cit.*, pp. 116 and 304–313. (2) War Department Circular No. 235, 12 June 1944.
[47] Smith, *op. cit.*, pp. 211–213.

lated. For definitive care in some areas of internal medicine and surgery, this example was splendid. It is worthy of note that some of the newer specialties—thoracic, plastic, ophthalmologic, and neurologic surgery—and dermatology were not strong in most of the Army general hospitals.

At the beginning of the war, the psychiatric sections under medicine were not well prepared for the enormous workload which occurred, and treatment facilities as well as qualified personnel were inadequate. Most large Army hospitals, including the general hospitals, had active treatment programs involving group, recreational, occupational, and art or music therapies fairly well started in 1942, but not until 1944 did the larger rehabilitation programs get underway. (See chapter X, "Station and Regional Hospitals.")

Because of a shortage of psychiatrists and because most of them, particularly in hospitals during 1941–43, were so busy with routine preparation of histories and examination of patients, formal reports and board proceedings, consultations, and involved disposition methods requiring voluminous letter writing, there was relatively little time and energy left for sustained individual treatment procedures even where these were applicable for the period of hospitalization. Administrative decisions at high levels actually determined admission, treatment, and disposition policies for the most part, as described by Brill (chs. IX and X) and by Farrell (ch. VI).

Expediency with regard to local problems usually governed decisions within the meaning and intention of the regulations, since the primary mission of the Army Medical Department was to support the field units. On the whole, almost all patients were furnished some type of treatment during their stay in the general hospitals, if it was at all possible, and often received careful attention to their total problem at a level which would have brought commendation in civilian hospitals. It is also commendable that most station hospitals also had active treatment programs utilizing specialized workers and outpatient services, even though these were not authorized by the War Department. Even electroshock therapy was utilized in a few hospitals, late in the war, in spite of restrictions placed upon this method of therapy.

Disposition of psychotic patients.—One of the most troublesome sources of administrative conflict, relative to the shortage of psychiatric beds during 1941–42, was the lack of places to transfer psychotic patients after they had received "maximum benefit" of hospitalization in a general hospital, although regulations, until 1944, pointedly emphasized discharge rather than treatment. During this time, a "psychotic" soldier could be discharged from a general hospital only after his LD status, Army Sanity Board (AR 600–500), and CDD board proceedings were approved by service command headquarters and if he could be received by legally responsible relatives, or a recognized civilian hospital. Usually, these procedures could not be readily accomplished. Such processing often

required a minimum of 6 to 8 weeks even if the psychiatrists were extremely prompt and accurate in the execution of necessary procedures. Most psychiatrists became experts in these phases of Army psychiatry because of the constant pressure to empty beds. The regulations during 1941–42 permitted psychotic patients to be discharged to Veterans' Administration hospitals if the LD was "Yes," but not if the LD was "No." These LD-No patients requiring further care could only be discharged to State hospitals, but during 1941, most States were reluctant to accept them except under pressure, and it was due to this barrier that the patient's transfer was often delayed from 3 to 5 months, except for a few States, notably New York, New Jersey, and Illinois.

The barrier to more rapid discharge of psychotic patients to a hospital near their homes was finally lifted in March 1943 when Congress authorized the Veterans' Administration to care for patients regardless of their LD status.[48]

TREATMENT

Type of Patients

By tradition and planning, the patients in general hospitals should have been principally those who presented the more unusual administrative and diagnostic problems, or those who could benefit by treatment facilities in such hospitals, not available elsewhere, particularly if this treatment was a prolonged procedure. To some extent, this was true in most of the general hospitals, although a number of large station and regional hospitals had excellent professional staffs in the medical and surgical specialties and, during 1941–43, were as well equipped in both personnel and equipment to give definitive treatment. This was particularly true in general medicine, general surgery, and orthopedic surgery in the better station and regional hospitals. After the peakload in 1943, the general hospitals became much more the treatment centers they were intended to be rather than having a majority of cases which required principally diagnosis and disposition. This was particularly true for the neuropsychiatric section or service during 1941–43, when the pressure for beds was as great as in station hospitals and general hospital treatment facilities were limited. Even though facilities for occupational therapy or active group therapy were not authorized in station hospitals early in the war, a number of those hospitals were permitted by local commanders and encouraged by service command consultants to establish these programs to do the most they could for their patients. It was soon obvious, in 1941, that, if station hospitals did not do this and thereby return a man to duty on the post, transfer to a distant general hospital away from his organization gave

[48] Public Law 10, 78th Cong., 17 Mar. 1943.

the patient a large secondary reward together with a high expectancy of discharge. It is regrettable that valuable manpower was lost this way, but it took all components concerned a long time to learn that the best way to keep a man with minor emotional problems or "occupational" maladaptation in the Army was to treat him as near to his company area as possible within the framework of a high expectancy of a return to active duty. Early in the war when manpower seemed plentiful and the widespread occurrence of psychosomatic disorders and somatic complaints associated with emotional conflict were not sharply delineated, many "obscure" cases including so-called organic neurological disease, dyspepsia, epilepsy, bowel distress, cephalalgia, and arrhythmia were transferred to general hospitals for diagnosis and treatment which could have been much better treated at the station hospital through an outpatient department or through a mental hygiene center. Partly acting in accordance with civilian prejudice that they brought with them into the Army that most if not all these behavioral disorders were organic, and partly in compliance with urgent requests by field officers to relieve them of their responsibilities, patients were transferred to general hospitals from which they often expected a CDD or they learned to use somatic symptoms to evade duty while undergoing prolonged diagnostic studies. For a more complete discussion of the patients diagnosed as psychoneurotic, the followup study by Brill and Beebe is recommended.[49]

Policies and Methods

In reviewing old records and in conversation with general hospital psychiatrists, it was gratifying to note that most of these medical officers remembered that they were physicians with an obligation to help sick people and therefore tried to do some type of individual therapy in selected cases, even though the time available for this purpose was very limited. There was little official encouragement to do therapy as the needs for beds increased as shown by Circular Letter No. 99, Office of The Surgeon General, 4 September 1942, and AR 615—360, of 25 May 1944, which stated that psychiatric patients "will not be retained for definitive treatment, but will be discharged * * *." Menninger has given an excellent account of the obstacles to good treatment which is worth reading.[50]

Psychosis.—Most disturbed psychotic patients became more controlled within a few days in the "neutral" hospital environment. Many psychiatrists have commented on the rapid subsidence of what came to be called a "thirty-day schizophrenia," in some circles.[51] Warm and cold packs for

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[49] Brill, Norman Q., and Beebe, Gilbert W.: A Follow-Up Study of War Neuroses. VA Medical Monograph Series. Washington: U.S. Government Printing Office, 1955.

[50] Menninger, *op. cit.*, pp. 293–319.

[51] (1) Brosin, H. W.: Panic States and Their Treatment. Am. J. Psychiat. 100: 54–61, 1943. (2) Ripley, H. S., and Wolf, S.: Course of Wartime Schizophrenia Compared With Control Group. J. Nerv. & Ment. Dis. 120: 184–195, September–October 1954.

sedation were valuable aids in those hospitals which had no continuous tubs. The latter were being installed in some hospitals, as late as 1943, although medical officers had to be sure that, to avoid accidents, reliable persons were in charge of operating the tubs. Chemical sedation often fell short of being satisfactory, so that medical officers were compelled to exercise personal supervision much of the day and night. "Dauerschlaf" (prolonged deep sleep) and deep insulin therapy were not practical in most places, because of the lack of trained nurses. Subshock insulin was not used until later in the treatment centers. It is noteworthy that, in spite of all these handicaps, most of the severely ill psychotics, not excluding the acute cases with rapid recovery, became amenable to treatment during the 3- to 4-month period of enforced waiting for transfer to another hospital.

Electroshock therapy was not authorized in general hospitals until Circular Letter No. 88, Office of The Surgeon General, April 1943, was issued; nevertheless, this therapy was not used in most general hospitals even after that date because of the lack of equipment, lack of training in its use, or a bias against it. However, when the treatment centers were established, it was used freely for depressed and agitated patients.

Neuropsychiatric Treatment Centers

Because of the lack of adequate facilities and of sufficient trained personnel and large treatment programs in many general hospitals, WD Circular No. 12, issued on 10 June 1944, authorized the establishment of psychiatric treatment centers at Mason, Bushnell, and Valley Forge General Hospitals, in addition to the one already at Darnall General Hospital. Psychotic prisoners of war were sent to Mason General Hospital, as provided by WD Circular No. 214, 15 September 1943.

Because of the increased number of patients, regional hospitals were established in April 1944 (WD Circular No. 140, 11 April 1944), and 22 general hospitals were designated as treatment centers in June 1944 (WD Circular No. 228, 7 June 1944).

Reconditioning Programs

Until the large convalescent reconditioning programs for hospitals were authorized by Circular Letter No. 168, Office of The Surgeon General, issued on 21 September 1943, there were no official directives encouraging active programs other than one of August 1943, Circular Letter No. 149, Office of The Surgeon General, 12 August 1943, which authorized personnel and equipment for occupational therapy departments in all general hospitals in the Zone of Interior. Although not authorized for station hospitals, these hospitals usually had active programs carried out by Red Cross workers and civilians. Recreation therapies of various kinds, includ-

ing athletic programs, bibliotherapy, group discussions, and music therapy, were carried on from the beginning of the war in accordance with the talent of the persons available, particularly among civilians and Red Cross workers.

Reconditioning programs received another boost when Circular Letter No. 203, Office of The Surgeon General, was issued on 10 December 1943. By this directive, all service command surgeons and commanding officers of all named general hospitals were ordered to establish reconditioning programs at once for all patients regardless of whether or not they were expected to return to duty. This theme became much more prominent later in the war, perhaps in response to civilian pressures, for the rehabilitation of returnees.[52]

During the period of acute need for manpower early in 1944, TB MED 28, issued on 1 April 1944, specifically directed, the first time, that psychiatric patients, including psychoneurotic patients, be treated. The bulletin also contained a comprehensive description of the methods available.

While most of the general hospitals had substantial programs, TB MED 28, in many instances, helped clarify the legitimacy of the work of the psychiatrist. The reconditioning programs were extended in scope by ASF Circular No. 175, issued on 10 June 1944. Provision was made for the transfer of suitable patients to an active program by the service command if the group at a hospital was too small.

Special Treatment Techniques

Hypnosis was used relatively little except by a very few men with some interest in this procedure. Most psychiatrists had no proficiency in it, probably because of the civilian attitude that it was not genuinely useful in most neurotic processes.

Interviewing patients with the aid of Sodium Amytal (amobarbital sodium) or Sodium Pentothal (thiopental sodium) was not uncommon in many hospitals, particularly in the hysterical amnesias and paralyses, and occasionally in criminal cases, since this was common practice in civilian hospitals after the introduction of the drug by Loevenhart, and Lorenz and its clinical utilization by Bleckwenn, in about 1927.[53] Later in the war, it was rarely used for abreaction in the manner commonly employed by overseas psychiatrists; rather, a refined technique was developed, called narcosynthesis.[54]

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[52] Menninger, *op. cit.*, pp. 293–300.

[53] Bleckwenn, W. J.: Narcosis as Therapy in Neuropsychiatric Conditions. J.A.M.A. 95: 1168–1171, 18 Oct. 1930.

[54] (1) Grinker, Roy R., and Spiegel, John P.: War Neuroses in North Africa. New York: Josiah Macy, Jr. Foundation, September 1943. (2) Grinker, Roy R., and Spiegel, John P.: War Neuroses. Philadelphia: The Blakiston Co., 1945. (3) Grinker, Roy R., and Spiegel, John P.: Men Under Stress. Philadelphia: The Blakiston Co., 1945.

Subshock insulin became popular in some psychiatric treatment centers as sedation for severely neurotic patients.

Group therapy of a more organized type in which selected patients would discuss their own and others' problems under the supervision and leadership of dynamically informed psychotherapists was comparatively scarce though it was encouraged by consultants. Many psychiatrists assigned to this duty developed methods which were suitable to their own interests and abilities including the question and answer techniques, didactic lectures on personality problems, types of maladaptation, therapeutic resources of the hospital and the Army, importance of attitudes in human relations, psychosomatic relations (with charts), and problems in the dynamics of living such as feelings of inferiority, dependency, projection, somatization, and "acting out." Following the success of TB MED 28, Col. (later Brig. Gen.) William C. Menninger, MC, was able to secure approval for further instructions in group therapy.[55]

In the final phase of the war, with thousands of oversea returnees and with civilian pressure which stimulated the interest of President Roosevelt and Secretary of War Stimson, a number of regulations and directives emphasized treatment of all levels for all neuropsychiatric patients, except those with chronic psychotic illness.[56]

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[55] (1) TB MED 84, 10 Aug. 1944. (2) TB MED 103, 10 Oct. 1944.

[56] (1) Army Regulations No. 615–361, 1 Mar. 1945, Changes No. 2. (2) War Department Circular No. 162, 2 June 1945. (3) Bull. U.S. Army M. Dept. 4: 358, July 1945.

CHAPTER XII

Troops in Transit

Morris M. Kessler, M.D.

HISTORICAL NOTE

Historical records from World War I with a neuropsychiatric significance for staging areas, ports, or oversea transports are meager. Lt. Col. Albert B. Kellogg,[1] in reviewing these data, dealt principally with certain highly publicized abuses in French ports of embarkation at the end of that war. The two reverse staging areas involved were Brest and Saint-Aignan, France. Poor arrangement of physical plant, improper discipline, and low morale of personnel, plus the fact that somewhere in the chain of command classification of sick and wounded was faulty[2] led to serious grievances that became headline stories in American newspapers. One article was captioned "Say Wounded U.S. Die in Mess Line in France." The report described how, at Saint-Aignan, mess lines were formed in a disorganized manner and were, consequently, very long; also, that the ground was muddy and unsuitable for negotiation by the ambulant sick and wounded who had to compete with able-bodied soldiers. This resulted in some unfortunate casualties. At the port of Brest, Colonel Kellogg noted an interesting psychological reaction among the soldiers awaiting passage. The men who had no assigned duties would start to line up for the next meal long before the appointed time. It seemed to be a commentary by the troops on the subject of boredom.

Colonel Kellogg also made some personnel observations at Hampton Roads Port of Embarkation where Negro troops were being staged for oversea shipment. Anxiety, based on the proximity of the Atlantic Ocean, led to a heightening of religious fervors. "Self-appointed preachers were as thick as mushrooms." Tenseness about the potentially dangerous ocean voyage was partially relieved by rationalizations such as "Well, that ain't so far" or "that water ain't very stormy." It is regrettable that Colonel Kellogg's compiled data did not include any formalized psychiatric observations of clinical cases either at the port of embarkation or en route overseas, so that a comparison might be drawn with the problems of troops in transit overseas in World War II.

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[1] Kellogg, Albert B.: Psychological and Psychiatric Reactions of Troops in Ports of Embarkation During World War I. Prepared in the Historical Section, Army War College, August 1942. [Official record.]

[2] Note how the same explanation for abuses repetitiously appears in the experiences of World War II.—M. M. K.

PORTS OF EMBARKATION

Function of the Psychiatrist

In many respects, the practice of neuropsychiatry in the staging area was little different from that found in other phases of military psychiatry during World War II. The staging area psychiatrist performed his duties in a conventional station hospital environment or in an outpatient clinic where, in addition to a consultative function, he carried out psychotherapy. He served the disposition and discharge boards. With regard to his own station complement, his decisions were neither crucial nor overly urgent. It was the crucial matter of making weighty and prompt decisions relative to the oversea shipment of particular individuals that constituted the unique function of neuropsychiatry in the staging area.

In an informative paper, Maj. (later Lt. Col.) Louis S. Lipschutz, MC,[3] reported on the special nature of the neuropsychiatric services in a staging area and the type of medical organization which was required for idiosyncratic requirements. He described the staging area as a stress zone where the unstable break down and the last stop before oversea and combat duty. Theoretically, psychiatric services for troops embarking for oversea duty should have been at a minimum if it was assumed that all necessary screening had been accomplished before arrival at the staging area. In this event, all personnel arriving at the staging area would have been fit for combat or general oversea duty. However, this was not always the case. Actually, the efficiency of training of combat troops was tested in the staging area by the extent of their need for medical services, particularly psychiatric consultation.

Organization of medical services

The organization of the staging area of the port of embarkation consisted physically of housing facilities (barracks) located in specific areas of the post. In the medical organization, it was found expedient to create in each of these housing areas a dispensary with relative autonomy from other medical or administrative departments; that is, the dispensaries were fully staffed and kept their own records. The military physicians assigned to these dispensaries had wide latitude in carrying out evaluation and treatment, even in the psychiatric sphere. It became quickly apparent that from 40 to 50 percent of dispensary calls at the staging area involved the emotional sphere.

In the station hospital serving the staging area were conventional open and closed psychiatric wards. The hospital psychiatrist offered a consultation service to the other medical departments as well as to the

[3] Lipschutz, L. S.: Symposium on Psychiatry in the Armed Forces; Neuropsychiatry in the Staging Area. Am. J. Psychiat. 100: 47–53, July 1943.

area dispensaries. Decisions had to be made promptly, often from a single consultation, as to whether the oversea bound soldier was to be sent on with his unit or kept for further observation and possible separation from the service. The psychiatrist was regularly faced with this dilemma: He must not recommend the unwarranted separation of a soldier from his outfit after he had undergone extensive training and had become an integral part of a unit. On the other hand, each fighting man overseas required the services of 5 to 9 men behind the battlelines in addition to large quantities of supplies, so that a useless soldier must not be permitted to make the voyage overseas.

Special programs

Duty-status approach.—Staging area neuropsychiatrists might have been helped in their special functions, somewhat, had they been able to benefit by the experiences of Lt. Col. A. Allen Goldbloom, MC, and Maj. Benjamin A. Schantz, MC.[4] These officers studied the maladjusted soldier to determine whether the emotional disorder which mushroomed out in the staging area was an adequate reason for separation from the service. They developed a special program at Camp Kilmer, N.J., where observation of a group of such problem soldiers could be carried out with the men on duty status, quartered in area barracks. Out of 185 patients, they found that 57 had to be discharged from the service under one of three Army regulations, 41 being separated for neurosis (medical discharge). Of the remaining 128, 84 were reclassified to limited service and 44 returned to general military service. Thus, 69 percent of the entire group was returned to duty status. Most of the cases originated from troops awaiting oversea shipments. In these soldiers, an acute psychiatric breakdown was induced by proximity to the port of embarkation. It was found that a high incidence of anxiety began with entry into the service, which remained latent until its florid outbreak in the staging area. Goldbloom and Schantz agreed with other investigators that there was a need for immediate, appropriate decisions in the staging area based on a number of factors, such as reversibility of anxiety, morale of the unit, and the like.

Outpatient approach.—Capt. George E. Poucher, MC,[5] the author's associate at Camp Patrick Henry Station Hospital for 2½ years during the war, recalls how unreasonably the inpatient facilities were being overtaxed until emphasis was shifted to outpatient services. At one point, 2 psychiatrists were trying to manage 150 inpatients, distributed in 5 neuropsychiatric wards, in addition to conducting an expanding consultation service. With the development of outpatient evaluation and treatment, the number of inpatients was reduced to a more reasonable caseload.

[4] Goldbloom, A. A., and Schantz, B. A.: The Management of the Emotionally Maladjusted Soldier at a Staging Camp. Psychiat. Quart. 20: 452–469, July 1946.

[5] Personal communication.

The size of the workload in this staging area neuropsychiatric outpatient clinic was approximately 300 patient visits per month with peakloads of as many as 1,800 per month during surveys, such as in the routine profiling of troops. This huge caseload was handled entirely by the two regularly assigned neuropsychiatrists.

Professional isolation

The Hampton Roads, Va., Port of Embarkation was one of the eight major American ports under the command of the Chief of Transportation. Although this port facility was located within the geographic boundaries of the Third Service Command, its chain of command went directly to the Chief of Transportation in Washington, D.C. Consequently, the medical facilities within the Transportation Corps were outside the control and supervision of this and other service commands. This was a mixed blessing from the start. The advantages were the autonomy and the ability to function independently, which frequently has its merits in wartime. The disadvantage, however, was the lack of communication with the next higher echelon and with the hierarchy in military psychiatry. This state of relative isolation was particularly disconcerting to the psychiatrist fresh from civilian life, because he had so many problems of adjustment to the policies, procedures, and methodology of the Army in general and to military psychiatry in particular. As a consequence, the psychiatric section or service at the port of embarkation developed its own complicated channels of communication, in addition to contending with the numerous internal problems that beset any organization of men. Communication with the Neuropsychiatric Consultants Division in the SGO (Surgeon General's Office) had to be accomplished through the intermediation of the port surgeon. The chain of medical command at the Hampton Roads port was most cooperative, but simple cooperativeness was no substitute for the direct, on the scene, visit of a psychiatric consultant. For this reason, many problems developed.

One of the problems in the early phase of the war was that general hospitals were not in an advanced stage of construction and thus were not ready to receive patients. Further, the medical sections of the Transportation Corps had no direct access to those general hospitals that were constructed. Initially, the vast majority of psychotic military patients were not considered to be in line of duty. This necessitated their transfer to public mental hospitals in the State of the patient's origin, when and if beds became available. Later in the war, with the change of regulations liberalizing service connection, psychiatric patients requiring further care could be readily transferred to nearby Veterans' Administration hospitals. However, in the early period of the war, before such change, correspondence with the various States concerned on the subject of the transfer of such patients was interminable and seemingly endless. As a result and

also because such patients could not be transferred to military general hospitals, they accumulated and remained incarcerated in the closed wards of the station hospital at the port of embarkation for months and months, creating crowded conditions and low morale. This state of affairs was further complicated by the fact that during this phase of the war active therapy (electric shock) was not permitted. There were some patients who were dangerous in the sense that they were overtly psychotic or severely psychopathic. Although they were clinically "insane," their minds had sufficient clarity for the plotting and organizing of riots. One such disturbance occurred at Camp Patrick Henry which ended only after the use of tear gas.

Finally, permission was granted to the psychiatrist of Hampton Roads Port of Embarkation to discuss the aforementioned problems with the psychiatric consultant to The Surgeon General in Washington, D.C. A solution was reached; namely, to place the medical facilities of the Transportation Corps under the Third Service Command, where regular communication with the supporting echelon proved to be the best answer to the local problems, both current and future.

The psychopathic personality

Major Lipschutz[6] found that 3 percent of dispensary patients were admitted to the station hospital and that 5 percent of those hospitalized were eventually transferred to the psychiatric wards. Although he encountered the usual cross section of psychiatric and neurological conditions he found that, in the staging area, the disposition by administrative discharge of pathologic personalities created an unusual difficulty. Apparently, in the press of departure, unit commanders failed to leave the necessary documents which would facilitate administrative discharge proceedings for men with undesirable habits and traits of character. In the author's experience, this problem was handled in routine fashion; patients were not permitted to be detached to the hospital without the necessary written evidence required for administrative discharge.

Maj. John M. Flumerfelt, MC,[7] writing on this problem, suggested the use of a—

> * * * standard size medical record paper, with one side divided into two halves —one half to contain a paragraph from the commanding officer of the soldier's unit, the other, a paragraph from the medical officer of the soldier's unit.
>
> Once the soldier has "made" sick call at the port of embarkation dispensary and the medical officer there decides that further information is required, such a form could be forwarded to the soldier's unit, filled out, returned by some other person than the soldier concerned and, altogether, handled in a confidential manner.
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> * * * Medical tactics would then determine whether the soldier should be ad-

[6] See footnote 3, p. 326.

[7] Flumerfelt, John M.: Psychiatric Problems in Military Personnel at Ports of Embarkation and En Route Overseas. *In* Military Medicine Notes. Army Medical Service Graduate School, 1951, sec. C, pp. 1–11.

mitted to the station hospital or its equivalent in the staging area, or whether the specialist examination should be conducted on an outpatient basis. As far as psychiatric examinations are concerned, there is no question but that an outpatient examination is indicated in all except acute psychotic disturbances and the most severe of the neurotic panic states.

Morale and Psychiatric Workload

The experiences of World War II demonstrated that the efficiency of both the training process and the medical screening in the prestaging operations was extremely variable. In addition, or perhaps in connection with the training phase, morale was a very important factor. Certain units were in such a high state of morale that it was well-nigh impossible to pry one soldier loose from his unit for even the most commendable of reasons. In other groups, morale conditions were reversed, and occasionally, it became necessary for command to declare a whole unit unfit or not ready for oversea duty. The experience of the neuropsychiatrist in the staging area could thus be described as feast or famine; either the pressure of his work was great or it was just average. More than the pressure of a workload, the staging area psychiatrist felt the onus of responsibility for his decisions to remove men from oversea shipments. He had to decide from clinical data how seriously sick the individual was and, then, to evaluate the degree of incapacity in relation to wartime needs for personnel. Frequently, a difficult and tenuous decision had to be made whether the morale of a unit would be better served by keeping the individual with his outfit or by removing him. It is true, the psychiatrist could obtain help in these decisions by conferences with unit commanders or by presenting the problem to a medical disposition board; however, in actual practice, it was his decision to make, and too often it was rendered on an emergency basis.

Personal experiences.—The following personal experiences illustrate the relationship of morale to the incidence of emotional disorders:

The hospital at Camp Patrick Henry was activated in December 1942. Medical officers arriving at the hospital just before Christmas were drafted immediately to aid in processing an emergency shipment of combat troops for overseas. It was a difficult time, and some of the wards in use did not even have heat. Yet, such was the pressure of the war, at the time, that the medical staff had to make do with unfinished facilities. Soon after this initial experience, a full combat division, battle ready and with high morale, was staged directly from the camp for an invasion onto the island of Sicily without restaging in Europe or Africa. As usual, it was found that such organized combat units with keen training and high morale offered no problem to the neuropsychiatrist. Very few men of this division were presented for psychiatric consultation, and almost all of them desired to remain with their units.

By contrast, another division came through the staging area en route to immediate combat activity. In this group, morale was at a low ebb. Previously, the division had been inspected several times to determine combat readiness but, in each instance, had been returned for further training. Finally, the division was declared combat ready and proceeded through the Hampton Roads Port of Embarkation for duty overseas. Yet, something was still wrong. The officers were dispirited. Many neurotic, including hysterical, personnel came to the clinics daily, but unit commanders refused to let these men be detached, and thus removed from the division. Many of the officers were fearful of certain "psychopaths" in their units who had threatened to shoot them "in the back" at the first opportunity which presented itself. The contrast between the two units was striking; it illustrated the extremes in morale which affected the workload of the psychiatrist.

The court of last appeal.—During one period of the war effort, a large group of combat troops was passing through Camp Patrick Henry. These men had had long periods of training and were considered ready to enter combat directly as replacement troops. On the day after their arrival, from the consultation room window, a group of men was seen on the roadway that led in front of the hospital area, presenting the strangest agglomeration of humanity that one could possibly imagine. Incredible as it may seem, there were men actually in wheelchairs pushed by others who limped and who apparently had something askew with their backs. There were men using crutches and improvised supports hobbling along the edge of the road. Those who were not crippled were bedraggled and unhappy. The group numbered well over 50, and it was only a few minutes later that it was discovered they were at the clinic for psychiatric consultation. No organic reasons were found for the apparent disabilities of these men, and it was readily ascertained that these subjects were mainly hysterical neurotics with longstanding histories of emotional illness. One or two, however, were seriously disturbed. The striking thing to bear in mind about this group of men was that they had been sent to the port of embarkation as combat ready. It became the task of the screening psychiatrist not only to keep such men from shipment overseas but also to bring this matter to the attention of the commanding officers of the staging installation for executive action. This entire shipment of men was eventually reentrained to the prestaging installation, and no doubt, some disciplinary action was taken against the responsible commander.

Operational Differences, Camp Kilmer versus Camp Patrick Henry

It is interesting to contrast some available workload statistical data between two comparable East Coast staging areas. This cursory study[8]

[8] Annual Report, Surgeon, Camp Kilmer, N.J., 1944, and notes by Capt. George E. Poucher, MC, the author's associate at Camp Patrick Henry, Va.

is presented because of certain findings which may be helpful in the organization of staging areas in any future wars. In 1944 and 1945, Camp Kilmer, N.J., of the New York Port of Embarkation functioned with a neuropsychiatric service, consisting of two specialists, as did Camp Patrick Henry, at the Hampton Roads Port of Embarkation. Camp Kilmer managed with the use of two psychiatric wards, one open and one closed. While such inpatient facilities were occasionally sufficient for the workload at Camp Patrick Henry, more often, in that period, one closed ward and two or three open wards were required. At Camp Kilmer, the psychiatric inpatient consultations averaged 50 per month, and outpatient consultations numbered 175 per month. At Camp Patrick Henry, the inpatient consultations were from 70 to 140 per month and the outpatient load was approximately 300 consultations per month. As already noted, one month at Camp Patrick Henry, during a survey of embarkation groups, 1,800 consultations were carried out in the neuropsychiatric clinic.[9]

Explanations.—There is no factual or logical explanation accounting for this large difference in psychiatric workload between the two staging areas, but speculation is possible on a few known variables. At Camp Kilmer, Goldbloom and Schantz (p. 327) conducted a program of rehabilitation for psychoneurotic-type patients, observing in particular a group designated as the emotionally maladjusted which were followed in clinic visits and finally disposed of by discharge from the service, by transfer to a general hospital, or by reassignment to duty. This program was mostly conducted outside the hospital wards. At Camp Patrick Henry, however, although psychoneurotic patients participated in a general rehabilitation program according to War Department directives, the policy of command relative to this group was undoubtedly different from that at Camp Kilmer, at least according to the author's recollection. Officers in charge of reassignment had little success in placing these patients and, after a brief period, urged the psychiatrists to make more and more definitive dispositions of such soldiers, other than transfer or reassignment. The result was that the patients in the rehabilitation group were either discharged from the service or returned to duty. With a larger number of men being recommended for discharge, the population of wards increased, which may account, in part, for the larger inpatient service at Camp Patrick Henry during the 1944–45 period of the war in comparison with that at Camp Kilmer.

Accounting for the larger difference in outpatient clinic consultations between these two staging areas is even more speculative. Information

[9] It is pertinent to note that no formal psychiatric program for staging areas was employed in the Korean War. Only an occasional psychotic was removed from troops in transit and at the port of embarkation; all others were shipped. This removed the necessity for psychiatrists to make impossible decisions for determining the eventual combat effectiveness of individuals from symptoms exhibited during this transit period. Moreover, it avoided the all too frequent World War II practice of unit commanders attempting to discard problem soldiers at the port of embarkation, many of whom later exhibited effective combat performance.—A. J. G.

available from the book "The Road to Victory" [10] is to the effect that the staging area at Camp Patrick Henry processed for oversea shipment only eight full size Army divisions during 1943 and 1944. Usually, Camp Patrick Henry was occupied with the processing of casual or replacement troops whose esprit de corps was at a low ebb rather than with organized units of high morale. Accordingly, the number of referrals for psychiatric consultations from these casual groups was very high. These men were seen as outpatients, and many were found to be psychoneurotic. It was assumed that the presence of such psychoneurotic disorders must have been known to command at previous stations. Thus, if the men were considered to be of sufficient value to complete training up to a port of embarkation, then it was also considered that they were deemed capable of proceeding overseas with their units even with psychoneurotic conditions. Of course, many of the more severe psychoneurotic individuals had to be detached from their units despite this general policy. In any case, the result was that the psychiatric clinic at Camp Patrick Henry became overloaded and the conclusion drawn was that the overload was due to the *nature of the units passing through the port of embarkation.* It was assumed that Camp Kilmer dealt more with organized divisions whose personnel had less motivation for separation at the port of embarkation. It has been generally conceded since the war that morale was generally better in units that had trained together than in newly formed units or individual replacements (p. 335).

Another factor affecting the large psychiatric caseload at Camp Patrick Henry was that, during the period of comparison with Camp Kilmer, the Station Hospital at Camp Patrick Henry also served as a regional hospital. This led to an unusual admission of patients from many nearby posts and stations for observation, study, and possible discharge from the service. With the increased patient load in the hospital for general medical and surgical reasons, the neuropsychiatric service received an added increment of cases.

The grand total of embarkations of all types at Hampton Roads Port of Embarkation was approximately 772,000.[11] It can be assumed that Camp Kilmer exceeded this number considerably, since it was associated with the largest East Coast port, New York, and was the embarkation area for the larger European theater. Hampton Roads served principally the smaller Mediterranean and Middle East theaters. For this reason, the disparity in the neuropsychiatric caseload is even more striking, notwithstanding the possibility that the available statistical data are derived from unequally weighted premises.

Recommendations.—Even though this attempted comparison of two East Coast embarkation facilities may not withstand close scrutiny by

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[10] Wheeler, William Reginald (editor): The Road to Victory. New Haven: Yale University Press, 1946.

[11] *Ibid.*

statistical analysts, its purpose was to establish that there were operational differences. It is believed that service personnel who are, as a rule, older and replacement troops, who are less highly motivated, present a greater problem to the psychiatric staff in a staging area than troops of organized divisions. Accordingly, it is believed that if one particular staging area will in some future war serve largely replacement troops and service personnel it should be provided with a very special organization in its neuropsychiatric service to meet an unusually large workload.[12] The department might be larger in staff and have more varied personnel and facilities.

TROOPSHIPS EN ROUTE OVERSEAS

Psychiatric Breakdowns

Little data are available on psychiatric breakdowns occurring en route overseas. Major Flumerfelt personally studied a British soldier after a suicidal attempt aboard ship. The case seemed to be a reaction to frustration; the soldier involved had had long service in Africa and, just when he expected shipment to his home, had found that he had been reassigned to the Near East. Major Flumerfelt also quoted a personal communication from Maj. Walter Musta, MC, who found that the less stable troops were more subject to seasickness. Maj. Theodore P. Suratt, MC, who was the 44th Division psychiatrist, did not recall any outstanding problem with the division troops en route overseas. Lt. Peter J. Brdar, who, while in service, was an officer of the Medical Administrative Corps but later became a psychiatrist, reminisced about a passage overseas on a Liberty Ship, as follows:

> The tiers of bunks were so close to each other that they brought out latent claustrophobic tendencies in troops. Seasickness in one or two men seemed to precipitate waves of mal de mer among the ranks.

These few items of information on the subject are very meager, considering the vast numbers of troops conveyed by ship to oversea theaters during World War II. The climate for the passage by ship should have been ideal for precipitating emotional breakdown. The ships were overcrowded, they were blacked out for security reasons, and there was the ever-present fear of submarine attack. A likely conclusion is that this phase of war medicine was not deemed valuable for intensive scientific

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[12] It is unlikely in future wars that the pressure of logistic demands would permit separate and exclusive staging areas for processing casual, or replacement, troops as distinguished from organized troop units. However, it has been repeatedly demonstrated in the past that the motivation of troops organized and trained together as a unit under good leadership is far superior to that of casual replacement troops, which have no such identity, thereby leading to fewer medical and administrative problems. It is for this reason that the Royal British Army has for the past century or more extolled the virtues of regimental banners and endeavored to promote individual pride in unit identity.—A. L. A.

study and recording because a certain percentage of emotional breakdown was to be expected under the existing circumstances.[13]

Morale

Casual troop replacements.—Lt. Col. (later Col.) M. Ralph Kaufman, MC, Neuropsychiatric Consultant, U.S. Army Forces, South Pacific Area, while en route overseas had an opportunity to conduct a questionnaire survey on a group of 800 casual troops sent abroad as replacements.[14] Although the replies to this questionnaire revealed a number of interesting aspects of the soldiers' attitudes toward their training and shipment to the Pacific Area, Colonel Kaufman made the following conclusions:

> Casual troops sent abroad as replacements present various differences from troops shipped as part of a well-integrated unit. Lacking a permanent organization and having no officers assigned to them, except casual officers who themselves are in the process of being shipped, the troops seem to lack an "esprit de corps." This reflects itself in their general morale. It is the impression of those who have to deal with them aboard ship, that, as a rule, they are more difficult and less amenable to the necessary discipline and routine aboard a crowded ship.

This experience with casual replacements has been mentioned so frequently that whole unit replacements should be the logical choice.

TRANSPORTATION OF MENTAL PATIENTS TO ZONE OF INTERIOR

Abuses Encountered

Lt. Col. Malcolm J. Farrell, MC,[15] Assistant Director, Neuropsychiatry Consultants Division, SGO, recorded an important chapter for the history of medical events in World War II by compiling some of the correspondence

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[13] Experiences of most psychiatrists en route overseas by troopship in World War II are similar to these just described. In fact, rarely were psychiatric problems presented for treatment aboard ship. The reason for this relative absence of psychiatric cases may very well be that neurotic gains in illness were inappropriate under these circumstances. Ships would not turn back, as everyone was aware. Here was a situation where psychological symptoms had no value whatsoever. In fact, sickness or other incapacitation would place a restriction on the few possibilities for recreation that were available and possibly decrease the chances of survival in the event of enemy attack. It is an interesting commentary upon the fact that the manifestation of psychiatric symptoms of a neurotic type are strongly influenced by external circumstances. Thus, there were very few psychiatric cases that demonstrated themselves during the first day at Pearl Harbor. Here again, there was no gain in illness. Navy psychiatrists report few psychiatric casualties at the time that ships are engaged in action. Again, gain in illness is impossible under these circumstances.

Nothing in the foregoing should leave the impression that personnel en route overseas during wartime did not suffer from anxiety, depression, and other psychological and psychosomatic symptoms. Almost everyone was under some personal or external pressure, and such discomforts were quite common. Seasickness, for instance, was frequent but here socially acceptable and certainly not gain producing.—A. J. G.

[14] Questionnaire Survey of Casual Troops (At Sea), 12 Oct. 1943, by Lt. Col. M. Ralph Kaufman, MC, Consultant Neuropsychiatrist, Headquarters, U.S. Army Forces, South Pacific Area, in collaboration with Lt. Col. Gordon M. Johnson, Cav., Code Commander, and Maj. John F. Carey, TC, Transport Command, with assistance of Capt. Bernard J. Goldman, MC.

[15] Farrell, M. J.: Evacuation of Mental Patients by Surface Ships. [Unpublished manuscript.]

which was conducted by the Neuropsychiatry Consultants Division with the consultants in two service commands, with the Chief of Transportation, and with the surgeons in command of oversea theaters on the subject of transportation of mental cases by surface ship to the United States. The steplike progress, from the spotlighting of the abuses to the recommendations for correction resulting finally in the issuance of orders covering the procedures to be followed, make for fascinating reading.

The abuses uncovered by Colonel Farrell in early 1943 may be summarized as follows:[16]

1. Inadequate accommodations aboard ship for long ocean voyages particularly through tropical weather.
2. Lack of qualified personnel, both officer and enlisted.
3. Difficulties in proper classification.
4. Problems specifically related to the closed-ward patients.

a. Returning Army transports carried most of the mental cases and the latter were relegated to an undesirable section of the ship which was poorly lighted and ventilated, or quickly constructed and improvised when mental patients were to be embarked.

b. Poorly informed general medical officers had a tendency to classify all psychiatric patients in one group, regarding them all as dangerous to themselves and to others.

c. Fundamentals of care such as nutrition and water balance were neglected.

d. Morphine was used as a sedative.

e. Violent patients were placed in metal cages measuring 6 by 3 by 3 feet.

Recommendations.—As a result of these abuses, Colonel Farrell, in a memorandum of 11 February 1943 to the Medical Practice Division, SGO, submitted the following recommendations relative to the abuses encountered:

1. Removal of physical hazards from rooms in which the mentally disturbed are quartered.
2. Judicious use of sedative drugs such as paraldehyde and the barbiturates along with adequate attention to fluid intakes, nourishment, and vitamins.
3. Review of the procedure for giving hydrotherapy along with a recounting of its attendant dangers.
4. Recommendations for diversional activities for mental cases.
5. Review of the proper restraint procedures.

Despite early awareness of serious abuses in the care of mental patients being returned to the Zone of Interior and the recommendations

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[16] (1) Report, Port Surgeon, New York Port of Embarkation, to The Surgeon General, 19 Jan. 1943. (2) See footnote 15, p. 335.

for the correction of such abuses, improvement was only gradually accomplished.

Use of cages for psychiatric patients

One of the important grievances in the transportation of neuropsychiatric cases to the United States was the use of cages on ship wards. These cages were made of wire mesh, were 6 feet long in a horizontal direction and, otherwise, approximately 3 by 3 feet in girth and height. With the mattress that it contained, there was insufficient headroom for the patient to sit up so that actually the use of the cage was quite inhumane. Maniacal patients had no freedom of movement. The nursing problem with regard to excretions was most difficult. It was quickly advised that these cages be abolished.[17] However, there were variant views on this subject, particularly from some ship surgeons and at least one port commander who believed that not all cages should be abolished but that a few should be left on each ship; otherwise, the transportation of this type of patient, understood so little and feared so much, would be too difficult a problem for medical and other attendant personnel. Finally, to control disturbed patients, orders were issued to place shock machines for electroconvulsive therapy on board these transports, and the medical officers in charge were given training in their use.[18] Specific recommendations were given about other types of psychiatric management of disturbed patients: Judicious use of exercise on the decks of ships, hydrotherapy, drug therapy, and the proper use of restraints. Although it could not be implemented during the war, it became almost a universal recommendation that ships transporting medical casualties as well as neuropsychiatric casualties should be air conditioned. Authorities were also of the opinion that the best mode of transporting the very sick mental patients was by air, for then time in transit would be brief and, thus, the use of heavy sedation rarely a great danger.

Improper classification of mental cases

The next reform concerned the removal of the stigma created by the letters "NP" on patient identification tags.[19] Apparently, fellow soldiers on transports looked upon men so designated as social pariahs to the consequent grief and consternation of the psychiatric patients. An order[20] was then issued providing that only a letter of the alphabet signifying the

[17] Circular Letter No. 35, Office of Chief of Transportation, U.S. Army, 1 Mar. 1943.

[18] (1) Memorandum, Chief, Neuropsychiatry Consultants Division, Office of The Surgeon General, for Medical Liaison Officer, Office of Chief of Transportation, 25 June 1945, subject: Electroshock Therapy Aboard Hospital Ships. (2) Letter, Chief, Movements Division, Transportation Corps, to Commanding Generals, Ports of Embarkation, 28 June 1945, subject: Electroshock Therapy Aboard Hospital Ships.

[19] Memorandum, Director, Neuropsychiatry Consultants Division, Office of The Surgeon General, for Lt. Col. John C. Fitzpatrick, MC, Transportation Corps, 27 June 1944.

[20] Transportation Corps Circular No. 50–31 (revised), 17 July 1944.

medical classification of the patient, according to a prescribed code, appear on the debarkation tag.

Proper coding[21] of mental cases involved the use of letters A, B, and C. The letter A was assigned to the patients who required locked-ward care either in hospitals or during transportation. The letter B designated the patients who might be cared for in open wards of a hospital but whose condition might not be adaptable to open-ward care on board ship. The letter C was for open-ward care in land hospitals or on ships.

It was found that faulty classification was purposely carried out to gain passage for closed-ward cases where such accommodations aboard ship were filled and open-ward spaces were still available. The transport surgeons then found, when the ship was at sea, that they had extremely difficult problems on their hands.

Accordingly, orders[22] went out demanding strict compliance with classification requirements for mental cases. Following this, efforts were made to provide psychiatric training in hospitals for officer and enlisted personnel (ship's complement) during their stay ashore. Unfortunately, according to the author's recollections, the initials "NP" were still on identification tags as late as 1945.

Deaths of psychiatric patients in transit

How hazardous the transportation of disturbed psychiatric patients could be is illustrated by the following statistics: The Port Surgeon of the San Francisco, Calif., Port of Embarkation reported on a period from April 1944 through October 1944. During that period, 2,980 mental patients had been debarked from the Pacific. In this group, there were 19 deaths of which all but 1 occurred in psychotic cases and that one was diagnosed neurosis. Of this psychotic group, nine were drowned (usually by jumping overboard while being exercised under supervision on deck), one died as a result of hanging, one died of diphtheria, three died of cardiac conditions, one died of malnutrition, one died of pyelonephritis, and two died of unknown causes. Of these deaths, 14 were on Army transports which carried the vast majority of Army cases and 5 were on Navy vessels.

Summary

In retrospect, it seems unconscionable that such abuses and inhumanities, as have already been enumerated, could occur in the first place;

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[21] (1) "Compilation of Instructions Pertinent to Hospital Ships," issued by Charleston Port of Embarkation, Charleston, S.C., 13 Feb. 1945. (2) See footnote 15, p. 335.

[22] (1) Letter, Commanding General, Army Service Forces, to Surgeon, Headquarters, North African Theater of Operations, U.S. Army, 10 Aug. 1944, subject: Transportation of Neuropsychiatric Patients From Overseas Theaters. (2) Teletype (73304), Lt. Col. John C. Fitzpatrick, MC, for Lt. Col. Donald E. Farr, Transportation Corps. 28 July 1944, subject: Accommodations of Open Ward Mental Patients En Route.

nevertheless, it is gratifying to know that organized authority was alert and sensitive to these defects and corrected them as rapidly as possible. Civilian pressure from newspapers and magazines upon military authorities probably contributed to the alacrity of correction in 1944 when returning soldiers made their complaints known.

Refinements in the humane care of mental cases kept appearing throughout the war. One such improvement concerned bringing class A and B patients up on deck if their emotional status and the weather conditions warranted it.[23] Another included an orientation of such patients to their return home. A third recommended a specified recreational program following certain military technical bulletins on the subject.

Hospital Ships

Psychiatric facilities

A medical history report[24] of the 211th Hospital Ship Complement aboard the U.S. Army Hospital Ship *Emily H. M. Weder* for 1944 is a classic for describing the imperfections of the existing hospital ships.

FIGURE 33.—Poster announcement of an occupational therapy exhibit aboard the U.S. Army Hospital Ship *Emily H. M. Weder.*

[23] Letter, Chief, Movements Division, Transportation Corps, to Commanding Generals, Ports of Embarkation, 21 Sept. 1944, subject: Sea Evacuation of Mental Patients.

[24] Sands, H.: Neuropsychiatric Nursing Aboard USAHS *Emily H. M. Weder.* [Official record.]

FIGURE 34.—The commanding officer inspecting one of the exhibits on the U.S. Army Hospital Ship *Emily H. M. Weder.*

This intimate annal of the war came to the author's attention through Maj. Matthew Levine, MC.[25] His principal service was on this large hospital ship which made important voyages in the Mediterranean and in the Pacific areas. His chief nurse in the neuropsychiatric section was Lt. Helen Sands, ANC. In her report, she traced the group's progress from its activation at Camp Kilmer to its real testing as a professional unit in a run from the Philippines to New Guinea with a full-bed capacity of class A psychiatric casualties (figs. 33 through 37).

Lieutenant Sands described lectures in basic theory and principles involved in normal and abnormal behavior given by Major Levine during the group's indoctrination period at Camp Kilmer. She elaborated at

[25] Levine, Matthew, M.D.: Personal communication to author. Major Levine surmises that he was one of the few Board-qualified neuropsychiatrists stationed on a hospital ship.

FIGURE 35.—Nurses admiring what their patients had accomplished aboard ship.

length about their adaptation to the physical appurtenances of the ship, in general, and the neuropsychiatric section, in particular. They devoted a great portion of their spare time to making their dayrooms (one of these rooms was originally a cargo hold) homey and attractive. She wrote:

> Both rooms are furnished with leather chairs and settees. We engaged in a ceaseless hunt for suitable pictures, and spent hours arranging them on the bulkheads; walls to you landlubbers. We decided that a bright spot was necessary; the gals came through with a bright red bookcase, hand painted. * * * it proved to be just what the room needed. * * * Our efforts are amply repaid whenever a patient enters the room, and with a wide-eyed stare exclaims, "Oh, brother, it's a long time since I've seen a room like this * * *."

Lieutenant Sands gave an interesting, detailed record of the nursing care afforded a practically mute psychiatric casualty with personalized attention from a few members of the group. The day-to-day progress report indicated how worthwhile it all was. One of the principal contri-

FIGURE 36.—Interested visitors at the Arts and Crafts Exhibit on the U.S. Army Hospital Ship *Emily H. M. Weder.*

butions to therapy of the disturbed patients evacuated in the South Pacific was the effective occupational therapy and judicious companionship given by the nursing personnel. It led to a comment by Major Levine: "That's one of our best methods of treatment, giving the patient pleasant women to talk to."

What was stressed in the report, however, was the absence of adequate ventilation and this was particularly underscored with regard to neuropsychiatric patients. It was pointed out that locked-ward cases could not use the decks at any time and that when the psychotic patients became disturbed, the problem became even more difficult because then their body temperatures rose. If, in addition, restraints had to be instituted, this increased the body heat and led to water loss. Also, as might be expected, disturbed patients refused to take the proper amounts of fluid, and this compounded the injury. It was charged that the average ward air temperature during a 14-day trip was between 105° and 110° F. Some of the wards were without portholes. One of the wards was near the hospital laundry which was operated 24 hours a day, adding greatly to the heat and humidity. With the terrible environmental heat, recreational and occupational therapy programs could not be carried out. In the latrines, the increased humidity added to the disturbance by the high temperature. Dermatitis became aggravated by the extreme heat, and this complicated the problems of the neuropsychiatric patients and the medical personnel

FIGURE 37.—Articles made of leather in the Arts and Crafts Exhibit.

in charge. All disturbed patients seemed to run temperatures. Working in an almost impossible environment produced an adverse effect on the morale of the nurses and ward attendants.

The report listed other defects in the physical appointments of the disturbed ward section (fig. 38). Overcrowding was a problem. Frequently, disturbed patients had to be kept together in confined quarters, and this made it extremely difficult if one of them suddenly became suicidal. The cells for individual care aboard ship were too few. There was a lack of soundproofed bulkheads. The panels enclosing cells for disturbed patients were not secure enough and were frequently broken through. The restraining sheets provided were not tailor made to the bunks found in hospital ships. Washroom facilities were inadequate. However, the most important thing stressed about the difficulties in hospital ship transportation was the matter of ward temperature and ventilation and, what was particularly recommended, was to have the hospital area air conditioned.

Hospital ship fatigue

The annual report from the U.S. Army Hospital Ship *Wisteria* for 1944 described an interesting syndrome among the personnel of the ship. It was called "hospital ship fatigue."

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FIGURE 38.—A ward on the U.S. Army Hospital Ship *Emily H. M. Weder.*

This was a definite entity characterized by insomnia, anorexia, irritability, slackness in work, and extreme persistent fatigue. Certain individuals with neurotic tendencies and social maladjustment were prone to attack. All personnel, however, experienced a certain degree of hospital ship fatigue which was usually arrested by time ashore. Up to the end of 1944, however, only one person had been put ashore with this diagnosis. Hospital ship fatigue was no different from the maladjustment to confinement and boredom found elsewhere. Apparently, it was not nearly so severe as the so-called "Arctic stare" seen in Greenland.

A convoy under attack

Capt. Jacob Sirkin, MC, in a letter communication, touched on many of the points of grievance mentioned elsewhere in this chapter; namely, the defects of a hospital ship; the faulty classification of closed-ward-type cases; and the transportation, without guards, of 30 general prisoners, convicted of various crimes, ranging from murder to desertion, on the neuropsychiatric wards. One of his experiences aboard the *Santa Maria* with a medical hospital ship platoon merits recording:

> We were traveling in convoy from England in December 1944 with about 60 "closed ward" patients. One night, there were a series of depth charges being exploded around us by the escorting vessels. This obviously meant to all of us that there might be a submarine in our vicinity. We were all rather jarred by the thought of the ship

getting torpedoed. I went to the closed ward to see how things were going. To my astonishment, I found that the doors were all open, with my corpsmen standing by. It seems that the patients had become agitated over the fact that they might be caught in a position where escape would be impossible because of locked doors if the ship were struck, and a quick agreement had been made by them and the corpsmen that they would stay where they were if the doors were left open, so that escape would be possible. To me, it was a magnificent display of good and quick thinking on the part of the corpsmen.

DEBARKATION OF MENTAL PATIENTS

From Ship to Hospital Train

The careful inspection by a service command neuropsychiatric consultant [26] of a ship-to-hospital train transfer of 171 neuropsychiatric patients resulted in a number of weaknesses in procedure being highlighted. He then initiated the type of communication at the command level that eased many of the stress points. Lt. Col. (later Col.) Henry W. Brosin, MC, made such an inspection at Hampton Roads Port of Embarkation. His recommendations pointed out the faults and suggested the antidote, as follows:

a. It is essential that the medical officers in charge of these convoys assign qualified medical officers, nurses, and enlisted men for the care of psychotics. The responsible medical officer should make an estimate of the situation upon arrival at the port, personally inspect and prepare the patients for transfer to the train, and personally supervise such transfer. He should also deploy his personnel in a most efficient manner and give specific instructions regarding the concrete problem of transporting psychotics. Irresponsible or indifferent corpsmen cannot be tolerated in movements of this kind for they will be the source of much criticism.

b. All officers agree that a thorough "on the job" training course is essential for enlisted men * * *. Trained enlisted men can make the trip a pleasure for themselves and the patients instead of a fearful, irksome job.

c. If feasible, an officer of the N.P. Staff should supervise transfers of psychotic patients from the ship to the * * * [general hospital of destination]. Where this does not seem feasible * * * the general medical officer can be coached relative to his duties with N.P. patients.

d. There has been a mistaken impression that the hospital cars are provided with leather anklets and wristlets for restraint. These could not be found by the responsible officers. The canvas camisoles which were present are not very useful. The hospital authorities are able and willing to provide the leather restraints in the future * * *.

e. A medical kit should be provided containing an arm board, syringes for intramuscular and intravenous use, Sodium Amytal and similar barbiturates for intravenous use, paraldehyde, bandages, antiseptics and stimulants such as coramine, caffeine, * * * and aphedrine for use in case of respiratory failure.

Staging Becomes Debarkation

Toward the end of the war in Europe, the status of the Station Hos-

[26] Report of Neuropsychiatric Consultant's Visit to Hampton Roads Port of Embarkation and McGuire General Hospital on 1–2 September 1944.

pital, Camp Patrick Henry, changed, as did the medical facilities in other staging areas. It was now to serve as a debarkation hospital for sick, wounded, and emotionally disturbed soldiers. Just before this change, the port of embarkation had served as a juncture point where hospital trains would meet the incoming shipments of casualties (fig. 39) and convey

FIGURE 39.—The U.S. Army Hospital Ship *Larkspur*, arriving at Charleston, S.C., 1944.

them directly to a general hospital. At the general hospital after a brief evaluation, casualties were classified for shipment to specialty hospitals. However, in 1945, the various general hospitals utilized for such screening were filled with their own specialty patients, which necessitated that classification procedures be done elsewhere. It was for this reason that the Camp Patrick Henry Station Hospital became a debarkation hospital, the chief function of which was to receive the shipment of casualties and to reclassify them, after a brief stay, for transfer to the appropriate specialty hospital.

One shipment came into this installation which consisted almost entirety of psychiatric casualties. Information was received some few days before debarkation that the shipment had 1,700 psychiatric patients. With a staff of only two trained psychiatrists, even the briefest type of screening was impossible for such a large number of patients. It was known

beforehand that the housing for these patients would have to be managed largely in area barracks and that only very special cases could be placed on the hospital wards. Accordingly, every available military psychiatrist, from nearby military hospitals, was recruited and deputized for this screening procedure. In addition, a number of other medical personnel were coached on a method of brief psychiatric screening. These men were to work in teams, each team under the leadership of a psychiatrist who would be available to review any particular case. The reception, feeding, and bedding down of this large group of psychiatric patients went off smoothly, and very few psychotic cases were housed in the closed wards. Every patient in the shipment was interviewed within a few hours of arrival. The average stay of such patients was 5 days, after which they were transferred to the appropriate specialty hospital.

CHAPTER XIII

The Mental Hygiene Consultation Services

Manfred S. Guttmacher, M.D.

HISTORICAL NOTE

In the World War I history of neuropsychiatry,[1] it was stated that the borderline psychiatric cases—the potential neurotics and psychotics—could provide a most fertile field for preventive psychiatry. It was also stated that the cantonment neuropsychiatrist "became the guardian of the mental health" of his military organization. Such worthy thoughts were actually more idealistic than real. Although some psychiatrists did occasionally leave the base hospital to do some preventive work in the field with line officers and enlisted men, there was no formal organization for such a preventive psychiatry endeavor. Psychiatric screening boards were appointed in camps to facilitate continuous screening, and surveys were conducted to eliminate the unfit—all of which was admittedly unsatisfactory from a rehabilitative procedure viewpoint.

At the beginning of World War II, the major emphasis was again placed on screening but more sage counselors, aware of the problems of World War I, realized that screening alone was insufficient to solve all the expected and unexpected neuropsychiatric problems.[2]

ORIGIN AND DEVELOPMENT

Formal Evolution

As early as April 1942, Lt. Col. (later Col.) William C. Porter, MC, Chief, Neuropsychiatric Service, Walter Reed General Hospital, Washington, D.C., sent a memorandum [3] to Brig. Gen. Charles C. Hillman, MC, Chief, Professional Service, SGO (Surgeon General's Office), outlining a plan for the assignment of neuropsychiatrists to replacement training centers.

[1] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, pp. 74-75.

[2] Acknowledgment is made to the excellent and very comprehensive recount of the consultation services by Dr. Marvin E. Perkins in "Medical Department, United States Army. Preventive Medicine in World War II. Volume III. Personal Health Measures and Immunization." Washington: U.S. Government Printing Office, 1955, pp. 171–232; and to Dr. R. Robert Cohen, whose manuscript on the consultation services was devoted almost entirely to the service at the Ordnance Replacement Training Center, Aberdeen Proving Ground, Md. Both of these have been used as references in this chapter.—M. S. G.

[3] Memorandum, Lt. Col. William C. Porter, MC, for Brig. Gen. Charles C. Hillman, 3 Apr. 1942, subject: Neuropsychiatry.

Colonel Porter strongly favored taking psychiatrists out of station hospitals and placing them up "front" near the line in both training and combat areas. His famous words, "Treat them within the sound of the artillery," were reiterated many times. The objectives of his plan were to (1) adjust the soldier to "his minor difficulties of maladaptation"; (2) "select out obvious mental defectives, psychopaths, or prepsychotics who have passed induction board or other entrance screen, provided the unit commander has referred the man as a problem in training, discipline, or administration"; and (3) "sell practical psychiatry to the line." To initiate this plan, he suggested that a specially selected small group of 10 neuropsychiatrists between 30 and 40 years of age be given a 6-week training course to orient them in the duties of training center psychiatrists that they would be expected to perform.

Shortly thereafter, Lt. Col. (later Col.) Patrick S. Madigan, MC, Chief, Neuropsychiatry Branch, SGO, officially recommended that neuropsychiatrists be assigned to the headquarters of each replacement training center. The Surgeon General[4] took immediate action to bring these recommendations to the attention of higher authority. Later, The Adjutant General allotted personnel spaces for 15 more Medical Corps officers, neuropsychiatrists with the rank of major, to the headquarters of the AGF (Army Ground Forces) replacement training centers. After the commanding generals of the 13 AGF replacement centers had requisitioned these psychiatrists, The Adjutant General[5] sent out a followup letter to assure their utilization in establishing psychiatric or behavior clinics independent of the camp hospital. Aware that in certain training centers such clinics were already functioning, the letter also cautioned against duplication of effort.

Recommended functions.—In outlining the functions of the center psychiatrist, this letter showed excellent foresight. The psychiatrist was "to eliminate those mentally unstable individuals who are or may become a distinct liability to military training, discipline, and morale during the early weeks of training," but he was, quite appropriately, to devote his time to the more normal individuals who may have developed correctible maladjustments to military service. An advisory service was to be instituted consisting of the psychiatrist, a psychologist, and "such other personnel as may be available." Eventually, Red Cross and military social workers and psychiatric social workers were added to the advisory team. The main purpose of the advisory team was to assist the new inductee in making a satisfactory adjustment in the Army. The duties of the psychiatrist were further detailed as follows:

(1) To aid, by professional methods, individuals who have been brought to his

[4] Letter, The Surgeon General, to the Commanding General, Services of Supply, 25 July 1942, subject: Assignment of Psychiatrists to Replacement Training Centers.

[5] Letter, The Adjutant General, to Commanding Generals, various Replacement Training Centers, 30 Oct. 1942, subject: Assignment of Neuropsychiatrists to Replacement Training Centers.

attention, in order to make full use of their training and capabilities, or to recommend reclassification of those who are being trained in a skill beyond their capacities; (2) to study and recommend remedial measures for those individuals who manifest behavior problems; (3) to recommend for immediate discharge from the service such men who, because of mental or emotional factors, cannot function adequately or who present a hazard to the other men; (4) to develop a liaison with line and medical officers for the purpose of instructing and developing a better understanding of the principles of mental hygiene as applied to the military services; (5) to aid in the morale program of the station by the use of the neuropsychiatrist's specialized training and knowledge.

Although the letter anticipated the sources of referral to the center neuropsychiatrist, it overlooked mention of two of the chief sources of referral, the other post medical units and the courts-martial agencies. It did mention (1) staff sections, (2) school directors, (3) chaplains, (4) company, troop, and battery officers, and (5) provost marshals.

Spontaneous Evolution

Independently and almost contemporaneously, mental hygiene units under diverse names were established in various training centers. Lt. (later Maj.) Harry L. Freedman, MC,[6] in February, 1942 established the Classification Clinic at the Signal Corps Replacement Training Center, Fort Monmouth, N.J. This clinic operated through the adjutant of the training center. Capt. (later Maj.) Bernard A. Cruvant, MC,[7] established his clinic at the Engineer Replacement Training Center, Fort Belvoir, Va. He used the term "Consultation Service" which was later generally adopted for all such mental hygiene clinics. The Belvoir clinic was frequently used by the Surgeon General's Office for training psychiatrists who were to be assigned to Consultation Services, not only because of its proximity to Washington but also because of its efficiency of operation.

Capt. (later Lt. Col.) Julius Schreiber, MC, established a clinic at the Antiaircraft Replacement Training Center, Camp Callan, Calif., similar to the one at Fort Belvoir. The relationship of motivation to the morale and efficiency of the soldier was emphasized by Captain Schreiber,[8] and he skillfully used the camp newspaper, pamphlets, and other media to disseminate information and advice.

The Consultation Service at Camp Callan originated as an outpatient clinic of the Station Hospital. In a somewhat similar manner, Maj. (later Lt. Col.) R. Robert Cohen, MC, Chief of Neuropsychiatry, Station Hospital, Aberdeen Proving Ground, Md., in August 1942, began to lecture to incoming trainees of the Ordnance Training Center on personal adjustment

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[6] (1) Freedman, H. L.: Role of Mental Hygiene Clinic in Military Training Centers. Ment. Hyg. 27:83–121, January 1943. (2) Freedman, H. L.: Services of the Military Mental Hygiene Unit. Am. J. Psychiat. 100:34–40, July 1943. (3) Freedman, H. L.: Unique Structure and Function of Mental Hygiene Unit in the Army. Ment. Hyg. 27:608–653, October 1943.

[7] Cruvant, B. A.: Symposium on Psychiatry in the Armed Forces; Replacement Training Center Consultation Service. Am. J. Psychiat. 100:41–46, July 1943.

[8] Schreiber, J.: Morale Aspects of Military Mental Hygiene. Dis. Nerv. System 4:197–201, July 1943.

problems. He believed that these lectures would aid in preventing the occurrence of common neuropsychiatric disorders. In the summer of 1943, the Consultation Service of the Ordnance Training Center was organized, and Major Cohen was appointed its psychiatrist. He wrote a number of articles[9] which emphasized the importance of assisting the new inductee in adjusting to the Army.

EXPANSION OF CONSULTATION SERVICES

In the fall of 1942, 13 new Consultation Services were established in AGF replacement training centers. The psychiatrists assigned to direct them were specially selected on the basis of their civilian experience in mental hygiene and related fields. Fortunately, most of these psychiatrists remained at the same posts throughout the war, and their efficiency increased with experience. They became more familiar with the local specialized training methods and the particular problems of the training center. It became evident, however, that it required time for line officers of the training centers to understand and acquire confidence in the psychiatrist and his methods.

There was general agreement by professional personnel of the Consultation Services that they performed more effectively if assigned to the headquarters of the center rather than if assigned to the hospital or the post surgeon.

In March 1943, Col. Roy D. Halloran, MC, recommended to Brig. Gen. Charles C. Hillman, MC, that Mental Hygiene Units (Consultation Services) should be established in all replacement training centers. At this time, there were Consultation Services in 16 of 33 basic training centers. As a result of Colonel Halloran's recommendation, all AGF and ASF (Army Service Forces) basic training camps had Consultation Services by the end of the summer of 1943. It was generally acknowledged, as reported by Colonel Halloran, that these units had proved of great value in assisting command in the adjustment of new recruits.

Conferences.—The first conference of Consultation Service psychiatrists was held in Washington, D.C., in the fall of 1943. This was a 3-day meeting held in the Neuropsychiatry Consultants Division, Surgeon General's Office. Many problems were discussed but the main conclusion was that motivation was the most important factor influencing the mental health of the soldier. Thus, it was agreed that closer liaison between the training center psychiatrist and the morale building agencies should be established.

In March 1944, a conference of all the psychiatrists directing the

[9] (1) Cohen, R. R.: Mental Hygiene for the Trainee; Method for Fortifying the Army's Manpower. Am. J. Psychiat. 100:62–71, July 1943. (2) Cohen, R. R.: Factors in Adjustment to Army Life: A Plan for Preventive Psychiatry by Mass Psychotherapy. War Med. 5:83–91, February 1944. (3) Cohen, R. R.: Officers and Their Relation to a Mental Hygiene Program for Trainees. Ment. Hyg. 28:368–380, July 1944. (4) Cohen, R. R.: Visual Aids in Preventive Psychiatry. War Med. 6:18–23, July 1944.

FIGURE 40.—Army Ground Forces Retraining Center psychiatrists' meeting, North Camp Hood, Tex., March 1944. Left to right, front row: Maj. George S. Goldman, MC, Lt. Col. Malcolm J. Farrell, MC, Maj. Samuel H. Kraines, MC, Maj. Alfred L. Abrams, MC, Maj. Juul C. Nielson, MC. Left to right, middle row: Maj. Jesse O. Arnold, MC, Maj. Richard F. Richie, MC, Maj. Harry E. August, MC, Maj. Oscar B. Markey, MC, Maj. Robert C. Hunt, MC. Left to right, back row: Maj. Vincent L. Frankfurth, MC, Maj. James Houloose, MC, Maj. Harry N. Roback, MC, Maj. Matthew Molitch, MC.

Consultation Services in the AGF replacement training centers was held at North Camp Hood, Tex. (fig. 40). The major portion of this meeting was given to the presentation and discussion of the "Advisor System." Maj. Samuel H. Kraines, MC,[10] had initiated and developed this "system" at the TDRTC (Tank Destroyer Replacement Training Center) at Camp

[10] (1) Kraines, S. H.: A Brief History of Psychiatry at the Tank Destroyer Replacement Training Center, Camp Hood, Tex., December 1942 to July 1945. [Official record.] (2) Kraines, S. H.: The Advisor System—Prophylactic Psychiatry on a Mass Scale. Ment. Hyg. 27:592–607, October 1943.

Hood, in February 1943. It was an attempt at prophylactic psychiatry on a mass scale. Specially selected and instructed noncommissioned officers in each company were used as advisers to the maladjusted soldier in the unit. Although Major Kraines apparently achieved success with the "Advisor System," the psychiatric group formally disapproved of the practice. The consensus was that noncommissioned officers were not adequately qualified, trained, or experienced to carry out effectively such a program and that command channels were ignored and circumvented.

PERSONNEL

Variations in Staffing

The staffs of the Consultation Services varied in size; only three had two psychiatrists. In one of these, which was in a camp where half of the trainees were Negroes, the second psychiatrist, Capt. Rutherford B. Stevens, Jr., MC, did an excellent job. The number of other assigned personnel, such as psychologists, social workers, and clerks, varied widely and was not always proportional to the camp strength. In one training center serving 7,500 troops, there was only one psychiatrist and one part-time clerk; whereas in another, serving 28,000 troops, 1 psychiatrist, 20 psychologists and social workers, and 20 clerks composed the staff. This staffing frequently depended upon how vociferously the psychiatrist demanded necessary personnel and how his efforts were accepted by the local command. The personnel needs, as outlined in War Department Technical Bulletin (TB MED) 156, of June 1945—1 psychiatrist and 1 psychologist to 12,000 trainees; 1 Red Cross psychiatric social worker to 20,000 trainees; and 1 military social worker and 1 clerical worker to 3,000 trainees—were considered minimal.

The rank of psychiatrists and psychologists also varied in the Consultation Services. In the AGF training centers, the policy was not to advance psychiatrists beyond the rank of major and psychologists beyond the rank of first lieutenant. Yet in the Army Service Forces, psychiatrists and psychologists performing the same duties were, respectively, advanced to lieutenant colonel and major. This inequality was not conducive to the best morale of psychiatric personnel. Further, keeping the psychiatrist at a lower grade did, in many instances, hamper his influence and reduce any effectiveness he might otherwise have achieved.

Clinical Psychologists and Psychiatric Social Workers

Two groups of nonmedical professional workers were found to be essential for the efficient functioning of the consultation services. They were clinical psychologists and psychiatric social workers.

Clinical psychologists

Clinical psychologists were in scarce supply, and only near the end of the war were they available in sufficient numbers for assignment to every clinic. Enlisted personnel (MOS 289) carried out much of the routine psychometric work. Commissioned clinical psychologists were primarily responsible for supervising the psychological testing program and for recommending the duty assignment of clinic patients. They carefully studied and analyzed the individual's experience, aptitude, and preferences. In addition, the clinical psychologists (generally designated as personnel consultants early in the war) kept abreast of the current Army personnel needs which were always of paramount consideration in job placement. Despite the limitations of available positions, appropriate recommendations for change of assignment proved to be a rather successful therapeutic technique.

Social workers

Social work was carried out by qualified Red Cross social workers and enlisted personnel. The number of Red Cross psychiatric social workers, however, was limited to the extent that these workers could be provided only for about one-third of the Consultation Services. In those units where both Red Cross and enlisted workers were stationed, there was, as a rule, a demarcation of functions. The Red Cross workers dealt mostly with community agencies and specially selected cases in which the root of the soldier's problem involved unfavorable home conditions or a marked degree of dependence upon the family.

As the functions of the Consultation Service and the work of the enlisted social worker became better defined, the scope and importance of that worker increased. In October 1943, psychiatric social work was first declared a military occupational specialty (MOS 263). In May 1944, such enlisted personnel were listed as critically needed specialists for the first time. This classification reasonably assured that they could be held in social work positions despite the Army's manpower needs. The "freezing" of enlisted psychiatric social workers created some difficulties. The Army Ground Forces were reluctant to use MOS 263 and generally used MOS 289 (Personnel Consultant Assistant), a less critical category. The Army Air Forces did not use MOS 263 until near the end of the war. It was not until June 1945 that TB MED 154, entitled "Psychiatric Social Work," was issued. Although rather late, it did give a much clearer definition of the duties and techniques of the military psychiatric social worker.

Relatively few fully qualified psychiatric social workers were available, although some military social workers and medical case workers had had considerable civilian experience. The Army psychiatric social work

was done by many such workers in allied specialties who received on-the-job training and supervision. Since the scope of military psychiatric social work was less complex than its civilian counterpart with its family and community ramification, these Army-trained workers gained considerable experience and competence. Military social workers remained on an enlisted status throughout the war, even though many efforts were made to obtain a commissioned status for them. Although WAC (Women's Army Corps) social workers and clinical psychologists were in the minority, those that qualified did effective work in the few Consultation Services to which they were assigned.

The military psychiatric social worker performed many related duties in the Consultation Services. The initial histories were usually taken by these social workers. The more professionally qualified workers did preliminary social work studies and evolved treatment plans to fit each individual patient. They decided which patients had to be seen personally by the psychiatrist and which needed further testing and interview by the clinical psychologist. Some workers, under the supervision of the psychiatrist, actually treated the simpler maladjustments. Many social workers did excellent and valuable work in the field. Preexamination company and battery interviews were conducted in most cases. The social worker not only interviewed the company officers but also visited the noncommissioned cadre and fellow trainees of the patient. Thus, they obtained a broad picture of the patient's personality makeup, his progress in training, his social adjustment, his personal attitudes, and his behavior abnormalities. Followup visits to the company areas were made after the original workup to ascertain whether recommendations were properly understood and carried out. This so-called "leg work" produced a close liaison between field units and the Consultation Service and was often responsible for obtaining many of the good results.

CONSOLIDATION OF EFFORTS

Lectures

With the publication of WD (War Department) Circular No. 48, issued on 3 February 1944, a new program for prophylaxis in mental health was advanced by the War Department. The circular contained outlines of three lectures on personal adjustment for enlisted men and a 6-hour lecture course for officers on personnel adjustment problems. The enlisted lectures were to be given during the trainees' first 2 weeks in the Army. All lectures were to be given by medical officers, preferably psychiatrists. The purpose of the lectures for the new trainees was to give a better understanding of common personal adjustment problems that may arise upon entering the Army and to present more effective methods of handling adverse emotions and feelings. The object of the

officer lectures was "to train company officers and noncommissioned officers in the importance of mental health in the Army, personality structure of the normal man, the causes of nervous break-downs, recognition of signs and symptoms of poor mental health, and measures to maintain mental health in the command." A few weeks later, the outlines for these lectures were published in more detail.[11]

Lectures for large groups of new soldiers were difficult to present. However, if the size of the group was decreased, more frequent lectures were required, involving more of the medical officers' time. The effectiveness of the lectures varied, depending upon the skill of the lecturer, his method of presentation, and the social and intellectual level of a particular group of trainees. Training aids were used extensively by psychiatrists. Some motion pictures were available, such as the British film, "The New Lot." Unfortunately, a corresponding American film was not completed soon enough to be used. Training charts, pamphlets, cartoon booklets, and even marionettes proved useful as training aids. The lecture outlines for officers proved to be most satisfactory. Both TB MED 12 and TB MED 21 were periodically revised to conform with the changes in existing situations.[12]

Psychiatric Problems of Basic Training

In 1944, in response to a request from the Office of the Secretary of War seeking information about psychiatric problems, the Neuropsychiatry Consultants Division made an interesting survey of 14 AGF and 7 ASF basic training camps. Constructive suggestions about psychiatric problems of their organizations, especially in connection with training, were requested of consultation service psychiatric personnel. Their comments are summarized, as follows:

1. Leadership:

Frequent reference was made by the Consultation Service psychiatrists regarding the commissioned officer in his relationship to morale and to the successful training of the soldier. There was wide recognition of the similarity of the soldier's emotional relationship to his company and his family, the soldier's response depending in a large measure on the unit commander as the father substitute. Many stated that the noncommissioned officers were really the most important men in the training program—the "men behind the gun" of Army training—and that they

[11] (1) War Department Technical Bulletin (TB MED) 12, 22 Feb. 1944. (2) War Department Technical Bulletin (TB MED) 21, 15 Mar. 1944.

[12] Personal adjustment lectures were continued on an optional basis after World War II, but were finally eliminated after the Korean War because of insufficient time for such lectures in the already crowded schedule of the 8-week basic training period. The effectiveness of such lectures in reducing the incidence of maladjustment in trainees has never been demonstrated. In recent years, Mental Hygiene Consultation Services have placed emphasis upon the informal and formal psychological indoctrination of the training cadre (officers and enlisted men). In this connection, a training film, entitled: "It's Up To You," has been produced.—A. J. G.

should be chosen by examination rather than solely by appointment, in which personal favoritism too often played a deciding role. The need for an increase in cadre personnel and for their continuity of service was stressed.

2. Psychiatric Understanding of Training Officers:

The consensus indicated that there was an increasing recognition, by line officers, of the emotional difficulties inherent in the new trainee situation and in the training objectives; however, there was a considerable lag in recognizing the individuality of each man. There were still too many officers who could not give up the prejudiced belief that the neuropsychiatric problem case was necessarily a "goldbrick."

3. Instructors:

The unevenness of the quality of instruction in the Army was stressed. Poor instruction was felt in many instances to be due to the officer's complete lack of interest and experience in teaching.

4. Training Methods:

Better planning of the training courses was suggested. One psychiatrist said: "The men should progress evenly from the less technical to the more technical phases, and from the less emotionally upsetting experiences to those of greater menace. For example, demolition comes in the third week. Men should not progress from the M–1 [rifle] through the carbine to the .22." There was much criticism of the fact that men from 18 to 38 years of age and men with Army General Classification Test scores, ranging from 50 to 150, were thrown into the same program which progressed at the same rate of speed. It was generally believed that there was almost exclusive emphasis on fear as an incentive to make the men learn, flooding the ego with undue anxiety. Realism rather than the all too general "you are all dead ducks" formula was suggested. Yelling and bullying were employed to an unnecessary extent. Yet, only rarely did the Plans and Training Division of the training center seek the advice of the center psychiatrist.

5. Infiltration Courses and Rifle Training:

The great majority of training center psychiatrists reported excellent educational plans with relation to the infiltration and battle courses. Some felt that too much emphasis was placed on competition in rifle training.

6. Relation of Basic Training to the Development of Psychoneurosis:

The chief factors in the training program producing psychoneurotic responses were listed as follows: (1) The difference in the mental and physical capacities of the trainees, all of whom are subjected to the same program and the same physical conditioning and learning pace; (2) inadequate recognition that this was the trainee's first experience in the Army and its attendant adjustments; (3) failure to recognize the difficulty in identification with a temporary unit; (4) inadequate flexibility in special opportunities for training and disposition of limited assignment

and useless men; and (5) lack of perception of the difficulty of learning to kill or be killed. It was recognized that these five factors in many instances served as a screening device to rid the Army early of many of those seriously psychoneurotically predisposed.[13]

It was feared that the stresses just cited tended to unstabilize men who would otherwise have been salvageable. A system similar to the Navy's, where, during the first 6 weeks, the unfit can be simply and expeditiously discharged as "unsuited for military service," was favored.[14]

7. Labor Battalions:

Of 21 psychiatrists questioned, 18 strongly recommended some sort of unit for slow learners and for the psychiatrically limited assignment soldiers, both to enable the slower soldier to adjust better and, of even greater importance, to increase the efficiency of the training of the normal group.

8. Orientation Problems:

It was generally agreed that there was defective orientation of the soldier: First, to his acceptance of the Army; second, to his job assignment; and third, to why we were fighting. One psychiatrist made a special point of the unfavorable morale factors in the guardhouse. He wrote:

> To me the greatest violence that is done to basic psychiatric principles is in the handling of men in the average guardhouse. These are men with poor morale, otherwise they would not be there. Instead of attempting to raise their morale, everything is done to crush their spirit. Every guardhouse should have a competent morale office and a full program of rehabilitation.

9. The Dispensary:

Several mentioned the great importance of the dispensary and the fact that when the dispensary officer had an inadequate understanding of psychological difficulties, he was ineffectual and even harmful to the unit.

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[13] Another typical example of the broad conceptionalization and usage of the term "psychoneurosis," in World War II, which seemingly encompassed all maladjustment and emotional reactions short of psychoses and, often, any predisposition for such disorders.—A. J. G.

[14] This recommendation has been made by several authors in this volume and was also a commonly expressed viewpoint of psychiatrists in World War II. It should be understood, however, that the Navy could accomplish such early and expeditious discharges of marginal personnel because its trainees were, for the most part in World War II, volunteers and not draftees. Conversely, the Army, during World War II, was composed mainly of draftees, and it was required by Selective Service to induct registrants who met physical and mental standards. Such draftees could only be discharged upon the documentation of unsuitability or unfitness for service because of either behavioral or medical reasons. The Navy volunteers could be separated by regulations established by the Navy without regard to Selective Service regulations. However, when the Navy separated such persons early in their training period, these volunteers were still eligible for the draft under the Selective Service. In fact, many of such discharged Navy volunteers were actually drafted and served in the Army.

It should be recognized that in a wartime period an early and expeditious discharge program would place a high premium on failure in the service. For this reason, the Army could not afford to implement such a desirable and easily attainable goal for its draftees, many of whom were not motivated for service. The Navy trainee who volunteered and thus avoided the draft process and Army service had an incentive to "make good," as failure would only make him eligible for induction into the Army. Therefore, it is evident that the Navy volunteer program could only work well when the selective service draft is in operation.—A. J. G.

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Central Supervision

On 15 September 1944, Maj. (later Lt. Col.) Manfred S. Guttmacher, MC, was assigned to the staff of the Neuropsychiatry Consultants Division, with the primary duty of supervising the 35 Mental Hygiene Consultation Services in the AGF and ASF replacement training centers. Major Guttmacher had had 2 years' experience directing Consultation Services in Antiaircraft Replacement Training Centers. During the year he was in the Surgeon General's Office, Major Guttmacher personally inspected all the Consultation Services.

Before Major Guttmacher's arrival in the Surgeon General's Office, a meeting of all training center psychiatrists had been planned. In order to obtain desired information and to stimulate interest in this meeting, Major Guttmacher sent a questionnaire to the chiefs of all the Consultation Services. The replies not only brought out much of the desired information but also determined the agenda for the meeting.

The 3-day meeting, 8–10 January 1945, was held at the Ordnance Training Center, Aberdeen Proving Ground, Md., with 38 training center psychiatrists attending. The conference was directed by Col. (later Brig. Gen.) William C. Menninger, MC, Director, Neuropsychiatry Consultants Division. Sick call, motivation and orientation, the Negro trainee, redeployment, neuropsychiatric disqualification standards for combat, courts-martial testimony, and the use of psychological testing agents were among the topics freely and informally discussed. The chief general conclusions[15] reached at the conference were as follows:

> Motivation plays a vital role in determining mental health. Insufficient realization by the average soldier of the degree to which he and his family were threatened by the enemy has been a basic cause for high incidence of psychiatric disorders among military personnel. Attempts to develop healthy attitudes toward the war have been relatively ineffective. It is the responsibility of the psychiatrist to point out the medical importance of this problem and lend full support to the I & E [Information and Education] Division and the command in its solution.
>
> Whereas the treatment and disposition of individuals suffering from psychiatric disorders must be continued, it is evident that the chief military value of a training center psychiatrist can be in the prevention of psychiatric disorders. The factors which determine mental health of military personnel such as motivation, leadership, training, job classification and assignment are functions of command. In these matters the psychiatrist can function only as an advisor to the command. In order to carry out this mission, it would be necessary for him to act as a staff officer. At the present time, limitation of assisting personnel barely permits the psychiatrist time to handle his heavy case load of treatment and disposition. Assumption of duties in regard to prevention must be gradual and depend upon the feasibility of adding further trained personnel to the consultation staff.

Personal experiences.—Despite the seriousness of this author's supervisory function, the periodic inspections of the Consultation Services also

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[15] Report, Maj. Manfred S. Guttmacher, MC, subject: Meeting of Consultation Service Psychiatrists held at Aberdeen Proving Ground, 8–10 January, 1945.

had their interesting and amusing moments. At one camp, the kindly commanding general asked to have his Consultation Service psychiatrist quietly replaced. This psychiatrist had sought the general's permission to eat with the hospital staff, with the complaint that "eating with all those line officers makes me nervous." Then, there was the training center where the general refused to allow men to be classified for limited service with the diagnosis of migraine unless it could be proved by roentgenograms. On a visit to a large western training camp, the inspecting psychiatrist pointed out to the commanding general that the high referral rate to the Consultation Services was only an index of his camp's poor morale. This statement was greeted with a volley of oaths befitting the proverbial sergeant and an accompanying declaration that one should not look for good morale in a camp with such a large proportion of Negro trainees. Within a week, the camp had a new commander. The Inspector General of another camp was telling of the invaluable service of the Consultation Services. He said that he had recently asked a warehouse sergeant what he did if a soldier kept complaining that the shoes issued him did not fit. The prompt reply was: "Send him to the Major at the Consultation Service."

OPERATION

Relationship With Command

The attitude of command influenced the Consultation Services just as it did all other agencies of the camp. For instance, the interpretation of Section VIII, AR 615–360, 26 November 1942, varied from a very liberal view to a very rigid one. Some commanding generals felt that ineffectual and behavior problem cases should be eliminated from the Army as soon as possible. Others felt that it was unjust and unwise from a morale standpoint to permit such persons to escape from their patriotic duties. So, where the policy was more liberal, the clinics referred many more men to the "Section VIII" boards. At the other extreme, such recommendations were not only disapproved by the commanding general but it was also impolitic for the psychiatrist to advise such disposition too frequently. There were many instances where the psychiatrist, with all due respect to command, had to follow a course tempered with justice. Often, commanders would eventually recognize their responsibilities and accept a more middle of the road policy. Rapidly shifting manpower needs and contradictory directives were mentioned as factors which often made it difficult for the psychiatrist to adjust his medical judgment to current policy. In that event, he could only give his best medical advice to the commander.

The usefulness of the Consultation Services was looked upon with considerable skepticism by many older Army officers in high staff positions at the training centers. Some believed it was wrong to exhibit so much

consideration for the individual soldier. They believed that this was molly-coddling and would weaken the fighting man. They averred that the mere existence of such clinics gave public and official recognition to the individual soldier's maladjustment or anticipated maladjustment. They also scorned the personal adjustment lectures, fearing that malingering would increase by giving the inductee medical information which he could divert to his own use. Such fears and worries were disclaimed by subsequent experience. Eventually, a great deal of dependence was placed on the staffs of the Consultation Services by most of the training officers. Through the combined efforts of the training officers and the Consultation Services, 80 percent of the maladjusted soldiers were able to complete their training, and those not amenable to corrective measures were expeditiously removed. It is impossible to estimate how much the war effort was benefited by disqualifying, during the training period, those serious psychiatric trainees who were mentally and emotionally unfit for combat duty. Similarly, it would not be possible to estimate how much maladjustment was prevented through the indoctrination of officers and trainees in the general principles of personal adjustment.

Some officers, of course, were so set in their ideas that they never would admit to the effectiveness of the Consultation Services. Other training center commanders highly praised the work of these services. Maj. Gen. Ralph M. Pennell,[16] Commanding General, Field Artillery Training Center, Fort Sill, Okla., expressed his opinions as follows:

> It would be very presumptious for me to tell you Training Center Commanders how to organize or operate the Consultation Branch of your S–1 Section or the duties you assign to the neuropsychiatrist in that section. Particularly is this true since my organization is based largely on what I learned from observing the operations of these sections in other training centers which I visited. I shall confine myself to covering in a few words some of the good work accomplished by an exceptionally well qualified psychiatric officer.
>
> First, he is never referred to by his formal designation. Doubtless, many men do not even know that he is a medical officer. He assumes the role of advisor and helper towards both the patients who may come under his observation and the battery commanders whose problem children they are. He has been able to train the classification personnel who interview incoming trainees so that they are able to spot men who may possibly have personal problems needing the attention of the battery commander and the psychiatric officer; that is, he discovers those who may give trouble *before* trouble arises. Battery commanders are given their names in confidence so they may be carefully observed from the beginning. A check-up over a period of months shows that probably 95% of those who are later before the psychiatric officer were spotted at this first interview by the classification section.
>
> Second, he has gained the complete confidence of the battery and battalion commanders and they seek his advice and help in handling difficult cases. He has also interested the first sergeants who are usually good judges of men. Incidentally, he learns what noncommissioned officers do not know how to handle men and they are weeded out if proper instruction cannot change them. By comparisons between bat-

[16] Annual Report, Neuropsychiatry Consultants Division, Office of The Surgeon General, U.S. Army, 1945, tab F.

teries of the number of men who have been cured of their fancied ills, he has secured a competitive spirit between the battery commanders. In other words, he has built up in these battery commanders a very strong interest in salvaging misfit personnel and building up in them a healthy spirit and frame of mind so that, instead of being sorry for themselves and wishing they were out of the Army, they complete their training with a new pride and self-confidence and with a desire to get out and take their part in winning the war.

Third, he works very closely with the summary court officer and the judge advocate to determine the most appropriate action to be taken in cases where offenses have been committed. I also use him to advise me as to the appropriateness of sentences adjudged by the courts. This may take the form of a conference between the JA [judge advocate], psychiatric officer, and myself.

In short, this psychiatric officer has a healthy view toward his duties. He has established very friendly relations with all battery commanders. They believe in and trust his decisions and work together to solve the personal adjustment problems which arise. He has done this with a minimum of overhead or red tape.

Procedures

During the first 48 hours of the training cycle, all new trainees were routinely interviewed by specially trained enlisted men. Men who had experience, aptitude, or genuine interest were selected for special assignments or attendance at the various post schools. The interviewers also noted new trainees who verbally or otherwise presented obvious psychiatric deficiencies. Enuretics, the very effeminate, those with significant psychosomatic complaints, and occasionally recent patients from mental hospitals were discovered early. The most severe were referred to the Consultation Service immediately (tables 18 and 19). Others were brought to the attention of the company commander and reported with their presenting problems to the center psychiatrist. Attempts were made to adjust these trainees to their new environment without psychiatric examination. Specific advice on how this might be accomplished was given to the cadre by

TABLE 18.—*Referrals to Consultation Service, by category, ASF Training Center (Ordnance), 1 June 1943–31 December 1944*

Category	1943				1944								Total	
	1 June–30 Sept.		10 Oct.–31 Dec.		1 Jan.–31 Mar.		1 Apr.–30 June		1 July–30 Sept.		1 Oct.–31 Dec.			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Intellectually inadequate	153	26.7	203	34.1	208	27.2	109	14.5	119	14.9	56	11.9	848	21.4
Psychosomatic	66	11.5	73	12.2	108	14.1	84	11.2	119	14.9	91	19.4	541	13.7
Administrative problems	50	8.7	21	3.5	24	3.1	35	4.6	28	3.5	19	4.0	177	4.5
Emotionally unstable	83	14.5	67	11.2	86	11.2	111	14.8	254	31.9	141	30.0	742	18.8
Physically disabled	173	30.2	185	31.0	272	35.6	325	43.2	212	26.6	115	24.5	1,282	32.4
Miscellaneous	48	8.4	47	8.0	67	8.8	88	11.7	65	8.2	48	10.2	363	9.2
Total	573	100.0	596	100.0	765	100.0	752	100.0	797	100.0	470	100.0	3,953	100.0

TABLE 19.—*Referrals to Consultation Service, by category, AGF Replacement Training Center (Infantry), 1 June 1943–30 November 1944*

Category	1943				1944								Total	
	1 June–10 Sept.		1 Oct.–31 Dec.		1 Jan.–31 Mar.		1 Apr.–30 June		1 July–30 Sept.		1 Oct.–30 Nov.			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Mental deficiency	266	50.8	117	32.5	96	18.7	116	24.6	149	25.7	61	18.5	805	28
Psychoneurosis	74	14.7	95	28.3	189	37.3	154	32.2	218	38.6	121	38.0	851	31
Psychoneurotic state	69	13.6	53	15.0	61	11.9	42	9.1	60	10.9	54	15.9	339	12
Psychosis	6	1.2	8	2.3	20	3.9	20	4.2	14	2.4	9	2.8	77	2
Physical defect	72	14.8	23	5.5	33	6.5	72	15.5	57	9.8	43	12.4	300	10
Enuresis	-----	-----	-----	-----	54	10.5	40	8.3	48	8.9	28	9.0	170	8
No disease	26	4.9	60	16.4	57	11.2	28	6.1	21	3.7	12	3.4	204	7
Total	513	100.0	356	100.0	510	100.0	742	100.0	567	100.0	328	100.0	2,746	100

TABLE 20.—*Consultation Service of mental hygiene clinics, Army Service Forces and Army Ground Forces, January–June 1945*

Location	Total trainees seen (percent [1])	Hospitalized (percent)	Discharged [2] (percent)
Army Service Forces:			
Fort Frances E. Warren, Wyo	4.00	8.00	7.70
Camp Crowder, Mo	3.35	3.61	5.69
Fort Lewis, Wash	2.80	5.00	8.20
Aberdeen Proving Ground, Md	[3] 1.50	2.30	26.00
Average	2.91	4.72	11.89
Army Ground Forces:			
Fort McClellan, Ala	[3] 1.40	5.10	9.60
Camp Livingston, La	[5] 4.00	6.00	9.00
Fort Bragg, N.C	4.00	3.50	5.06
Camp Wolters, Tex	3.80	5.80	21.80
Camp Howze, Tex[4]	3.00	12.80	10.80
Camp Croft, S.C	2.70	4.30	2.70
Camp J. T. Robinson, Ark	[5] 1.75	10.92	1.94
Fort Riley, Kans	1.28	8.70	7.80
Fort Bliss, Tex	1.16	8.20	13.77
Camp Blanding, Fla	.80	6.56	8.60
Average	2.38	7.18	9.10
General average	2.53	6.48	9.90

[1] Average percent of mean trainee strength seen each month.
[2] Under provisions of AR 615–368 and AR 615–369.
[3] Estimated.
[4] For period from March to June 1945, inclusive.
[5] Basis on which rate was calculated is not known.

the Consultation Service Staff. It was generally preferred to have new trainees examined psychiatrically, if necessary, after they were given 3 or 4 weeks of camp experience. Trainees who were thus able to adjust, in spite of their initial problems, developed more confidence in themselves and became hardier soldiers. By the same token, premature examination and disposition would have tended to undermine the confidence of the line officers in the psychiatrists. An indication of the caseload handled by the consultation services and of the dispositions that were made is given in tables 20 and 21, respectively.

Clinical Conditions

It is difficult to portray the vital activity—the comedy and the pathos—of the Consultation Services. Into them were funneled the misfits out of the host of bewildered civilians who were being transformed, in a few short months, into soldiers—a metamorphosis as miraculous as that of the caterpillar into a butterfly. There was a lad who was sent to the Consultation Services because of weeping. He was worried about his wife's having to carry their baby up and down the steps, which might affect her heart condition. His fear of getting bad news was so intense that he had not dared to send her his address. His civilian occupation had been painting flagpoles on New York office buildings and skyscrapers.

Then, there was the preacher of a small sect, not recognized as conscientious objectors, who was forced into the service and who, after a short time, decided to end it all. After wandering off into a swamp on the edge of his Georgia camp, he began cutting his wrists with a razor

TABLE 21.—*Disposition of cases, Consultation Service, ASF Training Center (Ordnance), 1 June 1943–31 December 1944*

Disposition	1 June 1943–30 Sept. 1944		1 Oct.–31 Dec. 1944		1 June 1943–31 Dec. 1944	
	Number	Percent	Number	Percent	Number	Percent
Full duty with no assignment limitations	1,529	49.1	329	39.2	1,858	47.0
Zone of Interior assignment	182	5.8	184	21.9	366	9.3
Transfer to Physical Training Company	700	22.5	101	12.0	801	20.2
Discharge	199	6.4	58	6.9	257	6.5
Medical treatment	143	4.6	55	6.5	198	5.0
Miscellaneous [1]	360	11.6	113	13.5	473	12.0
Total	3,113	100.0	840	100.0	3,953	100.0

[1] Includes enlisted men transferred to First Separate Training Battalion.

blade. Mosquitoes swarmed on him with such ferocity that he could not "take it" and ran out on the highway where he was rescued.

"Separation neuroses."—Pathological homesickness, aptly named "the separation neurosis" in the Army, was one of the striking clinical syndromes that developed in the new trainee. Essentially a reactive depression, it was generally associated with marked anxiety. It occurred mainly in the overdependent group and seemed especially prevalent in youths of Italian parentage. In the latter, an abnormally close attachment to the mother existed, despite the commonly large size of Italian families. Late weaning, a characteristic of this racial group, has been suggested as a possible contributing factor. Substitute dependence upon the wife was a presenting etiological factor in some cases of "separation neurosis." Most of the "separation neuroses" improved with the passage of time and under rather simple treatment techniques. Many soldiers reversed the problem and projected their own abnormal dependence upon the family, contending that the family could not get along without them. Red Cross field reports aided in having these patients realistically face the situation and accept their separation. There were, however, those whose ego structure was so weak that they could not adjust, and discharge in such cases was the most economical solution (fig. 41).

Enuresis.—Enuresis was a far more frequent problem than had been anticipated. Most cases were associated with mental deficiency or infantile and neurotic personality structures. There were a few cases in which it appeared as an isolated phenomenon in apparently stable individuals, for

FIGURE 41.—A patient with camptocormia reporting to the neuropsychiatric clinic. [From the film "Shades of Gray."]

any other defects that may have existed were not uncovered. This latter group, except for their specific deficiency, could have made capable soldiers. Thus, there was considerable inconsistency in the policy of discharging the enuretic. Extraclinical factors, such as manpower needs, the attitude of immediate superiors, and the attitude of command, all contributed to this inconsistency. Then, there were no sure techniques for curing enuresis, although many devices were tried. Waking the soldier at specified intervals, isolating from the rest of the barracks, deconditioning through shock of an electric current produced by the completion of an electric circuit by the urine, and elevating the foot of the bed and tying a towel knotted on the back or taping a 2-inch adhesive tape spool or small sack of sharp stones in the same area were all tried. A few malingerers feigned enuresis, but these were readily detected by the cadre through frequent and regular bed checks.

Homosexuality.—Homosexuality, although not very frequent, was always a difficult problem in the training centers. There was that pathetic group of homosexuals who had denied their abnormality to induction examiners and who had blindly hoped to adjust by living a robust life among thousands of normal military men. They frequently appeared voluntarily at the Consultation Service, desperately appealing for help. Others with strong latent tendencies developed psychosomatic disorders and acute anxiety states that also came to the attention of the Consultation Service. The handling of homosexual cases was often dictated by local command, and this also varied considerably. So the Consultation Service psychiatrist was again faced with a difficult and perplexing problem. As a rule, he was left with the ultimate function of interviewing the patient and seeing that justice was tempered with a mercy that was born of understanding.

Psychoneuroses.—The "psychoneurotics" made up, by far the greatest number of patients referred to the consultation services, with the anxiety states and the conversion hysterias predominating. The anxiety of the trainee was generally projected specifically toward some phase of the training, particularly the firing of the rifle, the battle course, and the conditioning marches. Patient reassurance from the training cadre, giving the individual insight into the nature and cause of his anxiety, pointing out that the specific focal point was merely a symbol of his attitude toward army duty as a whole, and adjusting him generally to army service, usually bore results. Many trainees expressed fear that they would never be able to kill another human being. In many instances, this was basically the fear that they themselves would be killed.

Distribution by diagnoses.—The percentage distribution of diagnoses in an Army Service Forces consultation service is shown in the following tabulation:

Diagnosis	*Percent*
Psychosis:	
Schizophrenia	0.5
Manic depressive	.1
Unqualified	.3
Total	0.8
Psychoneurosis:	
Anxiety state	18.5
Anxiety hysteria	2.3
Reactive anxiety	4.7
Hysteria	1.6
Conversion hysteria	1.6
Reactive depression	4.7
Hypochondriasis	2.6
Psychasthenia	.7
Neurasthenia	1.0
Emotional instability	6.3
Inadequate personality	3.9
Paranoid	.6
Somnambulism	.3
Neurocirculatory asthenia	.3
Acute nostalgic state	2.6
Paraphilia	.1
Unqualified	5.1
Total	56.9
Psychopatic personality:	
Chronic alcoholism	4.6
Drug addiction	1.7
Pathological liar	.1
Antisocial and amoral	2.4
Pathologic sexuality	1.1
Emotional instability	3.9
Inadequate personality	2.9
Schizoid personality	.8
Mixed type	2.4
Total	19.9
Mental Deficiency—educational:	
Retardation	12.0
Epilepsy:	
Grand mal	.2
Petit mal	.4
Total	0.6

Miscellaneous:	
Primary behavior disorder	2.5
Simple adult maladjustment	2.9
Scrimshanking (shirking duty)	.6
Enuresis	2.1
Stammering	.4
Post concussion syndrome	1.0
Migraine headaches	.1
Ill-defined condition, central nervous system	.1
Total	9.7
Grand total	100.0

LOCATION AND PSYCHIATRIC STAFF

Replacement training center psychiatrists (with rank then held) and the station to which they were assigned are shown in the tabulation which follows. It should be noted that, because of transfer and reassignment, several of the psychiatrists are listed for more than one consultation service.

Camp Abbot, Oreg.:
Maj. Arnold Eisendorfer
Lt. Kersten Gerhard
Aberdeen Proving Ground, Md.:
Lt. Col. R. Robert Cohen
Camp Barkely, Tex.:
Lt. Col. Donald B. Peterson
Fort Belvoir, Va.:
Maj. Bernard A. Cruvant
Maj. William H. Kiser, Jr.
Fort Benjamin Harrison, Ind.:
Maj. Harry E. August
Camp Blanding, Fla.:
Maj. Harry E. August
Capt. Morris J. Tissenbaum
Fort Bliss, Tex.:
Maj. Frank R. Barta
Fort Bragg, N.C.:
Maj. Alfred L. Abrams
Lt. Clarence P. Somsel
Camp Callan, Calif.:
Maj. Julius Schreiber
Camp Claiborne, La.:
Capt. Oscar M. Plotkin
Maj. Charles N. Sarlin
Lt. Daniel Silverman
Capt. George W. W. Little
Maj. James Houloose
Maj. Samuel H. Kraines
Camp Croft, S.C.:
Maj. Joseph L. Knapp
Maj. Vincent L. Frankfurth
Camp Crowder, Mo.:
Maj. Nathaniel J. Berkwitz
Maj. Clarence J. Kurth
Capt. Edgar M. Braun
Maj. Paul T. Hartman
Fort Des Moines, Iowa:
Maj. Albert Preston, Jr.
Fort Devens, Mass.:
Capt. Elvin V. Semrad
Capt. Rutherford B. Stevens, Jr.
Drew Field, Fla.:
Lt. Lewis L. Robbins
Camp Ellis, Ill.:
Lt. Maurice R. Friend
Fort Eustis, Va.:
Maj. Manfred S. Guttmacher
Camp Fannin, Tex.:
Maj. Oscar B. Markey
Capt. Kurt R. Eissler
Camp Gordon, Ga.:
Maj. James B. Craig
Capt. Isadore H. Cohen
Camp Gordon, Johnston, Fla.:
Lt. Col. Soll Goodman
Maj. Bernard A. Cruvant
Fort Hood, Tex.:
Maj. Harry L. Freedman
Capt. Benjamin Berger
Capt. Sidney J. Tillim
Maj. John J. Francis
Camp Howze, Tex.:
Capt. Oscar M. Plotkin

Capt. Stanley L. Olinick
Indiantown Gap, Military Reservation, Pa.:
Lt. William H. Anderson, Jr.
Capt. Samuel J. Sperling
Camp Kohler, Calif.:
Capt. Joseph C. Solomon
Fort Knox, Ky.:
Maj. Matthew Molitch
Lt. Clarence P. Somsel
Camp Lee, Va.:
Maj. Fred F. Senerchia, Jr.
Lt. Col. Samuel A. Sandler
Lt. Col. Soll Goodman
Camp Livingston, La.:
Maj. Frederic W. Brewer
Fort McClellan, Ala.:
Capt. Benjamin Berger
Camp McQuaide, Calif.:
Maj. Kenneth G. Rew
Mississippi Ordnance Plant, Flora, Miss.:
Lt. Clarence P. Somsel
Fort Monmouth, N.J.:
Maj. Harry L. Freedman
North Camp Hood, Tex.:
Maj. Samuel H. Kraines
Fort Oglethorpe, Ga.:
Capt. Harold J. Binder
Camp Plauche, La.:
Maj. Harry L. Freedman
Camp Polk, La.:
Lt. Robert R. Shopback
Fort Riley, Kans.:
Maj. Juul C. Nielsen
Camp Roberts, Calif.:
Maj. James Houloose
Maj. Harry N. Roback
Camp Joseph T. Robinson, Ark.:
Maj. Oscar B. Markey
Capt. Dominick F. Chirico
Camp Rucker, Ala.:
Maj. James Houloose
Camp Sibert, Ala.:
Lt. Col. Soll Goodman
Fort Sill, Okla.:
Maj. Jesse O. Arnold
Camp Stewart, Ga.:
Maj. Manfred S. Guttmacher
Maj. John J. Francis
Camp Wallace, Tex.:
Maj. Donald F. Moore
Fort Warren, Wyo.:
Capt. Paul M. Schneider
Capt. Rutherford B. Stevens, Jr.
Maj. Nathaniel J. Berkwitz
Capt. Stanley L. Olinick
Capt. Joseph G. Kapeca
Camp Wheeler, Ga.:
Maj. Elvin V. Semrad
Maj. George S. Goldman
Camp Wolters, Tex.:
Maj. Robert C. Hunt
Fort Leonard Wood, Mo.:
Maj. Eugene Davidoff
Capt. Norman Reider

CONCLUSION

Those who have had the opportunity of observing the Consultation Services in action throughout the Army are convinced that they should become an integral part of every Army Training Center in the future.[17] They are unique units, created, tried, and proved by World War II.

There was a time when war was a simple business, requiring little training and almost no specialization. But that time is long past. It was assuredly not true of World War II, and it will be even less so of the scientific warfare of the future. Armies are no longer made up of masses of men but of individuals welded together into special functioning units. The individualized approach to the soldier's adjustment has come to stay. For the present, and at least for some time in the future, a well-integrated

[17] This has already been accomplished. During and since the Korean War, "Consultation Services," now termed "Mental Hygiene Consultation Services," have become an integral part of not only every Army Training Center, but also of every sizable Army post in the Zone of Interior and of oversea divisions which have division psychiatric services as a part of their divisional medical services.—A. J. G.

organization composed of psychologists, social workers, and specially trained medical officers will be essential to the full efficiency of the Army.

Despite the amount of work thrust upon the training center psychiatrists, many considered it important to write articles presenting their procedures and results. Some of these articles were presented, during the war, at special meetings; some were published during the active fighting; and others, for security reasons, were not published until hostilities had ceased and security restrictions had been removed. All in all, the consultation service clinics compared favorably with the country's best civilian mental hygiene clinics.

CHAPTER XIV

Preventive Psychiatry

John W. Appel, M.D.

GENERAL CONSIDERATIONS

A history of preventive psychiatry in the Army during World War II should include an account of the mental health of the men in the Army during that period and of the factors which affected mental health, both favorably and unfavorably; and then, specifically, it should contain an account of the attempts by psychiatrists to influence favorably the mental health of Army personnel and the success of these attempts.

This sounds reasonable enough, yet at the outset it must be said that no satisfactory criteria existed then, or now, for appraising mental health. Application of the usual standards for the dichotomies—health–sickness, normal–abnormal—leads only to confusion when applied to mental, as distinct from physical, health. When a man is noneffective for mental reasons, is it due to sickness or to unwillingness? This proved to be a key question during World War II and still remains one which has yet to be answered satisfactorily. In a broader perspective, the history of mental health of the Army during that war period becomes an account of human behavior or, more specifically, an account of the factors which determined behavior, of the types of behavior which were considered desirable and undesirable, and, finally, of how undesirable behavior was labeled. Preventive psychiatry then becomes those actions taken by psychiatrists intended to produce desirable behavior in military personnel.

By the criterion of performance, it can be said that the mental health of the American soldier was good during World War II. The men fought long and well, and they won the war. On the other hand, most psychiatrists would say that the mental health of the average soldier was far from optimum and that the effectiveness of the Army would have been significantly greater if mental health had been better. Here, however, considerable difficulty arises in distinguishing between mental health and motivation to fight the war, which also was not optimum in the American soldier in World War II. Furthermore, it seems evident that the war had an adverse effect on mental and emotional health. By the time the war ended, many, if not most, personnel in the Army were showing signs of emotional wear and tear severe enough to be classified, according to psychiatric criteria, as sickness of at least a mild degree, but sufficient to

impair performance. This was more marked in men who had served prolonged periods in combat or in isolated outposts overseas. There is evidence that in several battle campaigns, particularly those in the Mediterranean theater, the breaking point of the average man was reached and that most men engaged in frontline duty ultimately broke down psychologically, or would have done so had they not been killed, wounded, or otherwise disabled.

SCOPE OF PROBLEM

The statistical data introduced here pertinent to the appraisal of the various phases of the neuropsychiatric problem deal, broadly stated, with the disqualifications for military service for neuropsychiatric reasons; with the incidence of neuropsychiatric disorders, as reflected in hospital admissions for such disorders; and with discharges for neuropsychiatric disorders. In interpreting the statistical data, specifically those related to admissions, it is important to recognize that they represent only rough indices of the actual incidence of psychiatric disorders in the Army, inasmuch as the criteria by which patients were so diagnosed varied widely during the war, as will be discussed subsequently in detail. The disqualifications for military service are evaluated first.

Rejections for Military Service

It has been estimated that 1,846,000 Selective Service registrants, 18–37 years of age, were classified as of August 1945 as IV–F—unfit for military service because of neuropsychiatric conditions. These disqualifications represented 38.2 percent of all World War II disqualifications for military service, or 11.5 percent of all registrants examined (appendix A, tables 5 and 7). The psychiatric criteria for rejection or acceptance varied considerably during the war. Most psychiatrists now believe that, in general, the criteria applied were too strict and that a sizable proportion of the rejectees could have rendered useful service had they been accepted.[1] Be this as it may, it does seem clear that the marginal segment of the population, those with the "poorest" mental health, had been screened out. The 11 million who served in the Army represented mainly the healthy young men of the country.

Hospital Admissions Worldwide

During World War II, there were 1.1 million admissions to hospitals for neuropsychiatric conditions—on a worldwide basis, indicating for the

[1] As a matter of fact, the psychiatric standards have been liberalized after World War II and fundamental changes have been introduced in the psychiatric screening procedures. *See* Karpinos, Bernard D.: Qualifications of American Youths for Military Service. Medical Statistics Division, Office of The Surgeon General, Department of the Army, 1962.—A. J. G.

entire war period a rate of 43.5 neuropsychiatric admissions per 1,000 mean strength per year (ch. IX, table 6). The neuropsychiatric admissions comprised 6 percent of the hospital admissions for all causes, or 7 percent of the hospital admissions for disease. The actual number of patients admitted for neuropsychiatric conditions was naturally smaller, since a certain proportion of these admissions were readmissions. It has been estimated that 960,000 patients were admitted to hospitals for neuropsychiatric disorders. These patients represented approximately 9 percent of all those who served in the Army in World War II.

From the viewpoint of prevention, the most important question to ask is what these data imply relative to the mental health of the other approximately 91 percent of the Army. The inpatients had neuropsychiatric disorders considered serious enough to require removal from duty and admission to a hospital. But, as was gradually realized during the war, a mental and emotional disorder cannot be compared to a clinical entity, such as typhoid, for example, which a person either does or does not have. Rather, such disorders were analogous to nutritional deficiencies and varied, in degree, from completely disabling to relatively minor discomfort. Thus, for every psychiatric case serious enough to require hospitalization, there must have been many more cases of lesser severity among personnel who remained on duty. Therefore, the hospitalization rate was chiefly significant as an index of the mental health of the population in which it occurred.

Diagnostic distribution

Of the total number of admissions (1.1 million) for neuropsychiatric disorders, 15.8 percent were for neurological disorders; 6.1 percent for psychosis; 58.8 percent for psychoneurosis; 10.8 percent for character and behavior disorders, among which the most prevalent was immaturity reaction; 2.6 percent for disorders of intelligence; and 5.9 percent for other psychiatric disorders (ch. IX, table 9). Evidently, the bulk of these disorders consisted of psychoneurosis. There were wide variations in the total admission rates from year to year, and especially from month to month, primarily due to changes in the admissions for psychoneurosis. The admission rates for other diagnostic categories, specifically for neurological disorders and psychosis, remained relatively constant. (See chapter IX, tables 6 and 8 and chart 2.)

Psychoneurosis has been a well-established diagnostic term with fairly well established criteria for its application. It connoted that the person was psychiatrically sick. There is no question that a large proportion of the patients so diagnosed during the war actually did have this condition. Yet, during the war, it was concluded that this term had been widely misapplied throughout the Army and that a large proportion of the personnel admitted to hospitals with this diagnosis actually did not have

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this illness; rather, they were persons whose ineffectiveness was due to faulty attitudes, deficient motivation, or "poor" character.

Significance of hospitalization

According to Army policy, particularly during the first years of the war, if a person became so ill as to be unable to perform his job satisfactorily, there was no place for him except in the hospital. This, of course, is in marked contrast to the situation in civilian life where, if one has a head cold or a sprained ankle, it is possible for him to take off a couple of days and stay at home. In the Army, a person with such minor ailments had to be hospitalized or, under exceptional conditions, confined to quarters. This hospitalization for minor disorders had a profound psychological effect on personnel in producing gain in illness, which will be discussed subsequently. In the present context, however, it should be clear that although the 1.1 million neuropsychiatric admissions represented personnel sufficiently sick to be ineffective in their jobs, by and large they were not so sick as to require hospitalization as it usually occurs in civilian life.

It would also be a mistake to conclude that the 1.1 million neuropsychiatric admissions represented personnel who had "broken down" in the service. A significant proportion were soldiers hospitalized as a result of the constant screening process which was carried out throughout the Army, particularly during training. The trainees hospitalized in this process frequently were no sicker than they were before entry into the Army; it had merely been concluded by the examining medical officer, that, according to the current manpower policies, these persons were psychologically unsuited to their current duties and required reassignment or return to civilian life.

Differentials in admissions for neuropsychiatric disorders

Different factors affected the hospital admissions for neuropsychiatric disorders. Those affecting the admissions in continental United States are not the same as those in the oversea theaters, and especially in combat areas. Therefore, these admissions will be discussed separately—first, the admissions in the continental United States will be appraised, and then, those in oversea theaters.

Hospital Admissions in Continental United States

Of the 1.1 million admissions for neuropsychiatric disorders in World War II, on worldwide basis, 679,000 admissions (ch. X, table 14) (or 61.5 percent of all admissions) were in the continental United States and 424,000 admissions (table 22) (or 38.5 percent of all admissions) were in oversea theaters.

The World War II admission rates were 45.8 in the continental United States (ch. X, table 14) and 40.2 in oversea theaters (table 22)—for 1,000 mean strength for the year. The admission in continental United States included trainees having difficulties in their initial adjustment to Army life, persons being screened out of the Army as unsuited to military service, and soldiers becoming incapacitated while on duty status in the various Army installations in the Zone of Interior.

Of the neuropsychiatric admissions in continental United States, 15.8 percent were for neurological disorders and 84.2 percent for psychiatric disorders, the latter containing 5.6 percent psychosis; 57.5 percent (the majority of the cases) psychoneurosis; 12.1 percent character and behavior disorders; 3.6 percent disorders of intelligence; and 5.4 percent, other psychiatric disorders (ch. X, table 15).

The admission rates in continental United States for neuropsychiatric reasons, specifically for psychiatric disorders, varied widely, from year to year and from month to month. The most striking feature was the sharp increase in the admission rate for neuropsychiatric conditions that occurred in the second half of 1943. The admission rate in continental

CHART 5.—*Admission rates for neuropsychiatric disorders, U.S. Army, total worldwide, continental United States, and oversea theaters, by month, 1942–45*

[Rate expressed as number of admissions per 1,000 mean strength per year]

United States, which had fluctuated early in 1943 around 40, rose in August 1943 to a high level of 67.6 per 1,000 mean strength per year—a relative increase of 28 percent. The rate declined abruptly toward the end of the year almost to the earlier lower level (table 23; chart 5). Both this rise and fall reflected changes in policies and criteria for admitting patients to hospitals and, evidently, were in no way related to changes in the actual

TABLE 22.—*Admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, overseas, 1942–45* [1]

[Rate expressed as number of admissions per 1,000 mean strength per year]

Diagnosis	Total 1942–45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Neurological disorders: [2]										
Epilepsy	3,930	0.4	358	0.6	887	0.5	1,450	0.4	1,235	0.3
Other	63,250	6.0	3,524	6.0	13,551	8.0	22,665	5.9	23,510	5.2
Total neurological disorders	67,180	6.4	3,882	6.6	14,438	8.5	24,115	6.3	24,745	5.5
Psychiatric disorders:										
Psychosis	29,818	2.8	1,651	2.8	5,182	3.1	12,125	3.2	10,860	2.4
Psychoneurosis	257,891	24.5	6,559	11.2	43,007	25.4	117,050	30.7	91,275	20.6
Character and behavior disorders:										
Pathological sexuality	1,674	0.2	48	0.1	271	0.2	825	0.2	530	0.1
Asocial and antisocial personality types	1,002	.1	15	.0	42	.0	265	.1	680	.2
Immaturity reactions [3]	16,617	1.6	987	1.7	3,395	2.0	6,275	1.6	5,960	1.3
Alcoholism	16,879	1.6	1,142	2.0	2,972	1.8	5,220	1.4	7,545	1.7
Acute	(12,126)	(1.1)	(910)	(1.6)	(2,146)	(1.3)	(3,705)	(1.0)	(5,365)	(1.2)
Chronic	(4,753)	(.5)	(232)	(.4)	(826)	(.5)	(1,515)	(.4)	(2,180)	(.5)
Drug addiction	218	.0	19	.0	39	.0	100	.0	60	.0
Enuresis	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	[1] NA	340	.1	280	.1
Total	37,010	3.5	2,211	3.8	6,719	4.0	13,025	3.4	15,055	3.4
Disorders of intelligence	4,514	0.4	271	0.5	1,173	0.7	2,000	0 5	1,070	0.2
Other psychiatric disorders	27,922	2.6	884	1.5	4,648	2.8	11,185	2.9	11,205	2.5
Total psychiatric disorders	357,155	33.8	11,576	19.8	60,729	36.0	155,385	40.7	129,465	29.1
Total neuropsychiatric disorders	424,335	40.2	15,458	26.4	75,167	44.5	179,500	47.0	154,210	34.6

[1] See footnote 1, table 6, chapter IX.

[2] See chapter XVIII, "Neurology," table 60, for detailed diagnostic distribution.

[3] This diagnosis includes 145 admissions for "pathological personality," not elsewhere specifically classified.

NOTE.—Figures in parentheses are subtotals. The entry .0 indicates a rate of less than .05.

incidence of neuropsychiatric disorders. In May, again in April, and then again in July 1943, memorandums [2] from the War Department pointed out that too many men with neuropsychiatric disorders were being shipped overseas and ordered that increased efforts be made for their detection and elimination.

On 14 July 1943, WD (War Department) Circular No. 161 eliminated the category of limited service and ordered the discharge of all men who

TABLE 23.—*Admissions for neuropsychiatric disorders, U.S. Army, worldwide, continental United States, and oversea theaters, by month, 1942–45*

[Rate expressed as number of admissions per 1,000 mean strength per year]

Month and year	Total worldwide [1]		Continental United States		Oversea theaters	
	Number	Rate	Number	Rate	Number	Rate
1942						
January	4,598	30.6	4,194	31.2	404	25.4
February	4,641	30.3	4,212	31.3	429	23.0
March	5,877	31.0	5,282	32.2	595	23.6
April	6,248	30.4	5,661	32.8	587	17.9
May	6,981	30.4	6,123	32.1	858	22.1
June	8,189	33.8	7,053	35.5	1,136	25.9
July	9,498	35.6	8,155	37.9	1,343	26.3
August	10,802	37.0	9,266	39.7	1,536	26.4
September	11,895	38.2	10,150	40.8	1,745	27.9
October	13,544	37.8	11,643	40.6	1,901	26.8
November	14,470	36.6	12,406	39.4	2,064	25.6
December	17,312	38.6	14,452	40.0	2,860	32.8
Total	114,055	35.2	98,597	37.1	15,458	26.4
1943						
January	18,413	37.9	15,215	38.9	3,198	33.8
February	18,197	39.2	15,125	40.2	3,072	34.9
March	23,295	42.4	19,295	43.3	4,000	38.4
April	24,940	45.5	20,140	45.8	4,800	44.4
May	26,173	44.9	21,240	46.4	4,933	39.6
June	28,702	50.0	23,130	51.8	5,572	43.6
July	33,798	55.2	26,000	56.1	7,798	52.4
August	38,970	63.5	30,950	67.6	8,020	51.4
September	36,163	60.6	28,285	64.8	7,878	49.2
October	34,842	56.5	26,785	61.1	8,057	45.1
November	30,568	50.9	21,955	53.0	8,613	46.1
December	27,026	43.3	17,800	42.9	9,226	43.9
Total	341,087	49.6	265,920	51.3	75,167	44.5

See footnote at end of table, p. 380.

[2] (1) War Department Memorandum No. W600–30–43, 25 Mar. 1943. (2) War Department Memorandum No. W600–39–43, 26 Apr. 1943. (3) War Department Memorandum No. W600–62–43, 29 July 1943.

TABLE 23.—*Admissions for neuropsychiatric disorders, U.S. Army, worldwide, continental United States, and oversea theaters, by month, 1942–45*—Continued

[Rate expressed as number of admissions per 1,000 mean strength per year]

Month and year	Total worldwide [1]		Continental United States		Oversea theaters	
	Number	Rate	Number	Rate	Number	Rate
1944						
January	27,030	43.0	17,545	43.9	9,485	41.4
February	24,695	41.6	15,085	41.7	9,610	41.5
March	25,305	39.8	14,575	39.1	10,730	40.8
April	22,960	36.5	13,085	37.4	9,875	35.3
May	27,830	42.0	15,475	43.6	12,355	40.1
June	27,170	42.1	13,965	41.7	13,205	42.6
July	33,150	49.1	14,020	41.3	19,130	56.9
August	31,165	46.3	16,320	49.7	14,845	43.0
September	37,010	56.4	20,055	65.9	16,955	48.2
October	37,595	56.2	17,950	60.9	19,645	52.6
November	37,775	57.9	15,460	57.0	22,315	58.5
December	36,130	54.0	14,780	56.7	21,350	52.2
Total	367,815	47.2	188,315	47.4	179,500	47.0
1945						
January	35,780	54.3	14,465	57.6	21,315	52.3
February	29,690	45.1	11,460	48.0	18,230	43.5
March	31,595	47.2	12,230	52.3	19,365	44.4
April	31,205	46.5	11,985	51.1	19,220	44.0
May	29,830	43.5	12,180	51.2	17,650	39.3
June	26,930	40.1	12,155	49.6	14,775	34.6
July	24,985	37.3	12,275	45.7	12,710	31.7
August	22,910	34.6	12,550	43.2	10,360	27.9
September	16,275	25.3	8,880	29.8	7,395	21.4
October	13,470	22.9	7,935	28.8	5,535	17.6
November	10,305	21.4	5,735	25.9	4,570	17.5
December	7,135	19.1	4,050	21.8	3,085	16.5
Total	280,110	37.7	125,900	42.2	154,210	34.7

[1] See chapter IX, tables 7 and 8.

did not meet the minimum standards for induction. By September 1943, the disability discharge rates of enlisted men reached a peak of 35.6 per 1,000 mean strength per year for neuropsychiatric disorders, and a rate of 105.9 for all medical reasons; in other words, these discharge rates increased to such a level that 225,000 enlisted men per year would have been discharged—for neuropsychiatric conditions—or 660,000 enlisted men per year—for all types of medical conditions—had these discharge rates continued throughout the year. (See chapter IX, table 3 and chart 1.)

On 3 November 1943, the War Department temporarily suspended all discharges. This was followed, on 11 November, by instructions (WD

Circular No. 293) which represented a basic change of manpower policy from that of *screening* and *elimination* to one of *conservation* and *utilization.* Men with psychiatric disorders were to be kept in the Army if medical officers considered them capable of rendering useful service (pp. 207–213). Their discharge was firmly prohibited. The rise and fall of admission rates in 1944 also occurred as the result of similar policy changes. (For further details, see chapter IX.)

Hospital Admissions in Oversea Theaters

Overall evaluation.—As mentioned before, 38.5 percent of the World War II admissions for neuropsychiatric disorders, or a total of 424,000

TABLE 24.—*Percent distribution of admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, overseas, 1942–45* [1]

Diagnosis	Year				
	Total 1942–45	1942	1943	1944	1945
	Neuropsychiatric Disorders				
Neurological disorders: [2]					
Epilepsy	0.9	2.3	1.2	0.8	0.8
Other	14.9	22.8	18.0	12.6	15.3
Total	15.8	25.1	19.2	13.4	16.1
Psychiatric disorders:					
Psychosis	7.0	10.7	6.9	6.8	7.0
Psychoneurosis	60.8	42.4	57.2	65.2	59.2
Character and behavior disorders:					
Pathological sexuality	.4	.3	.4	.5	.3
Asocial and antisocial personality types	.2	.1	.1	.2	.4
Immaturity reactions [3]	3.9	6.4	4.4	3.4	3.9
Alcoholism	4.1	7.4	3.9	2.9	4.9
Acute	(3.0)	(5.9)	(2.8)	(2.1)	(3.5)
Chronic	(1.1)	(1.5)	(1.1)	(.8)	(1.4)
Drug addiction	.1	.1	.1	.1	.0
Enuresis	[1] NA	[1] NA	[1] NA	.2	.2
Total	8.7	14.3	8.9	7.3	9.7
Disorders of intelligence	1.1	1.8	1.6	1.1	0.7
Other psychiatric disorders	6.6	5.7	6.2	6.2	7.3
Total psychiatric disorders	84.2	74.9	80.8	86.6	83.9
Total neuropsychiatric disorders	100.0	100.0	100.0	100.0	100.0

See footnotes at end of table, p. 382.

TABLE 24.—*Percent distribution of admissions for neuropsychiatric conditions, by diagnosis and year, U.S. Army, overseas, 1942–45* [1]—Continued

Diagnosis	Year				
	Total 1942–45	1942	1943	1944	1945
	Psychiatric Disorders				
Psychiatric disorders:					
Psychosis	8.3	14.3	8.5	7.8	8.4
Psychoneurosis	72.2	56.7	70.8	75.3	70.5
Character and behavior disorders:					
Pathological sexuality	0.5	0.4	0.5	0.5	0.4
Asocial and antisocial personality types	.3	.1	.1	.2	.5
Immaturity reactions [3]	4.7	8.5	5.5	4.0	4.6
Alcoholism	4.8	9.9	4.9	3.4	5.8
Acute	(3.5)	(7.9)	(3.5)	(2.4)	(4.1)
Chronic	(1.3)	(2.0)	(1.4)	(1.0)	(1.7)
Drug addiction	.1	.2	.1	.1	.1
Enuresis	[1] NA	[1] NA	[1] NA	.2	.2
Total	10.4	19.1	11.1	8.4	11.6
Disorders of intelligence	1.3	2.3	1.9	1.3	0.8
Other psychiatric disorders	7.8	7.6	7.7	7.2	8.7
Total psychiatric disorders	100.0	100.0	100.0	100.0	100.0

[1] See footnote 1, table 6, chapter IX.
[2] See chapter XVIII, "Neurology," table 60, for detailed diagnostic distribution.
[4] This diagnosis includes 145 admissions for "pathological personality," not elsewhere specifically classified.

NOTE.—Figures in parentheses are subtotals. The entry .0 indicates a rate of less than .05.

admissions, occurred in oversea theaters. Detailed statistical data relating to these admissions for all oversea theaters are presented in table 22, by year and diagnosis; in table 23, by year and month, side by side with those for total (worldwide) and for the continental United States, for comparative purposes (these data are graphically shown in chart 5); in table 24, showing the percent distribution of the oversea admissions by year and diagnosis; and in table 25, presenting the total World War II admission rates for the total (worldwide), continental United States, and oversea theaters, by diagnosis.

These statistical data clearly indicate lower frequencies of neuropsychiatric disorders in the oversea theaters, when viewed in toto. As stated before, the total admission rate for World War II for neuropsychiatric disorders was 40.2 in oversea theaters compared with a rate of

45.8 percent in the continental United States, per 1,000 mean strength per year. With the exception of few months (December 1943, and June, July, and November 1944), the rates in oversea theaters were definitely lower for each month of the World War II period (table 23, chart 5). It must be realized, of course, that certain screening took place when troops were sent overseas, outside of the fact that certain proportions were weeded out much before oversea assignment. Among the specific diagnoses showing definitely lower admission rates in oversea theaters were immaturity reactions, disorders of intelligence, and to a certain degree psychoneurosis.

TABLE 25.—*Admission rates for neuropsychiatric disorders, U.S. Army, worldwide, continental United States, and oversea theaters, by diagnosis, 1942–45*

[Rate expressed as number of admissions per 1,000 mean strength per year]

Diagnosis	Total worldwide [1]	Continental United States [2]	Oversea theaters [3]
Neurological disorders:			
Epilepsy	0.7	1.0	0.4
Other	6.2	6.2	6.0
Total neurological disorders	6.9	7.2	6.4
Psychiatric disorders:			
Psychosis	2.7	2.5	2.8
Psychoneurosis	25.6	26.4	24.5
Character and behavior disorders:			
Pathological sexuality	0.2	0.3	0.2
Asocial and antisocial personality types	.1	.1	.1
Immaturity reactions	2.6	3.5	1.6
Alcoholism	1.7	1.7	1.6
Drug addiction	.1	.1	.0
Enuresis	[4] NA	[4] NA	[4] NA
Total	4.7	5.6	3.5
Disorders of intelligence	1.1	1.6	0.4
Other psychiatric disorders	2.6	2.5	2.6
Total psychiatric disorders	36.7	38.7	33.8
Total neuropsychiatric disorders	43.5	45.8	40.2

[1] See table 6, chapter IX.
[2] See table 14, chapter X.
[3] See table 22.
[4] "Not available." See footnote 1, table 6, chapter IX.

NOTE—.The entry .0 indicates a rate of less than .05.

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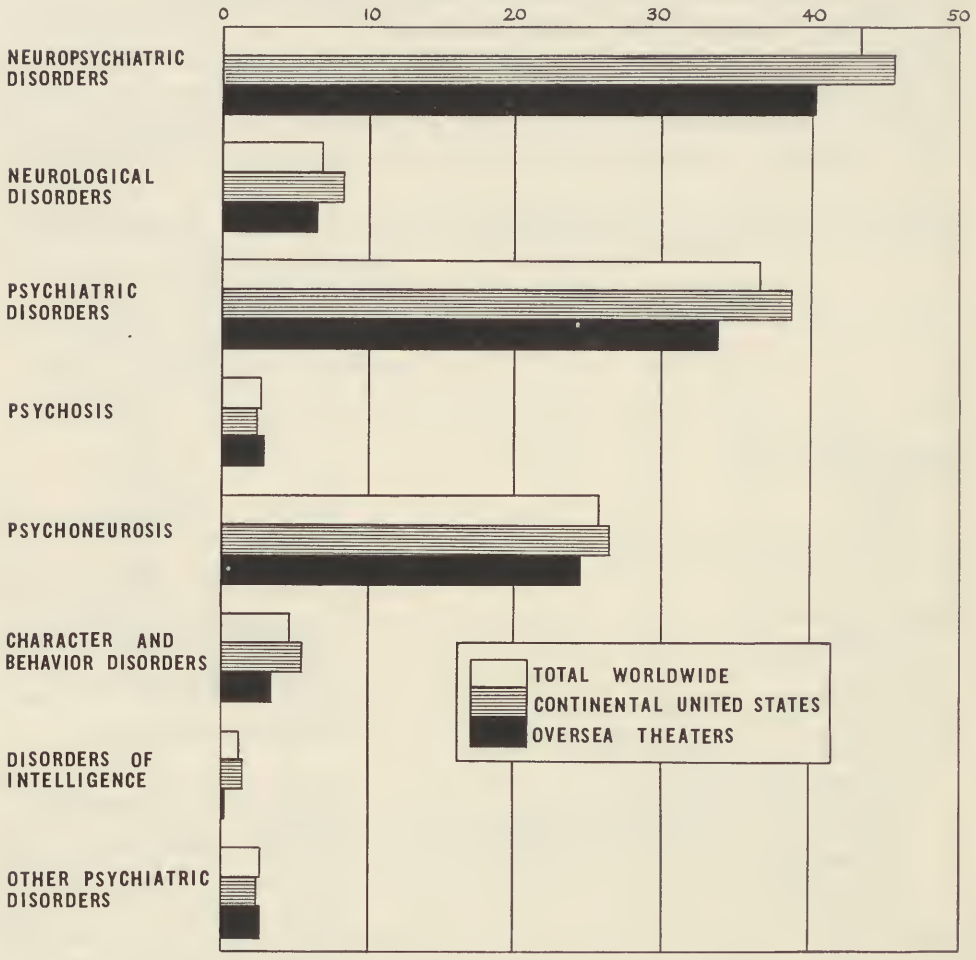
CHART 6.—*Admission rates for neuropsychiatric disorders, U.S. Army, worldwide, continental United States, and oversea theaters, by diagnosis, 1942–45*

[Rate expressed as number of admissions per 1,000 mean strength per year]



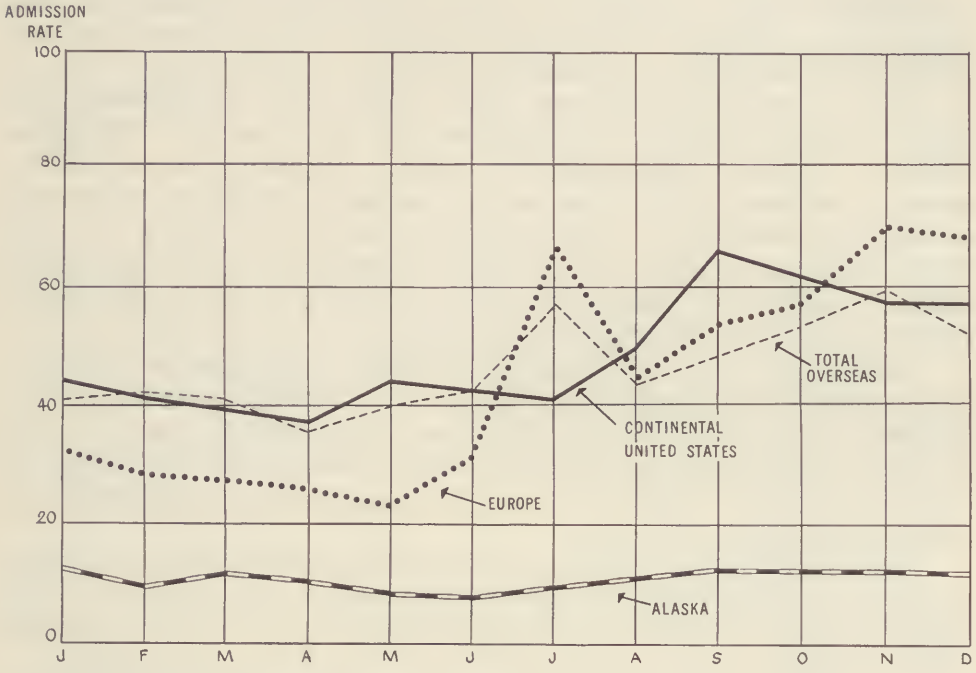
Psychosis indicated a somewhat higher admission rate in oversea theaters than in the continental United States (table 25, chart 6).

The admissions for neuropsychiatric disorders in oversea theaters were distributed by diagnosis as follows: 15.8 percent, neurological disorders; 7.0 percent, psychosis; 60.8 percent (again the largest proportion), psychoneurosis; 8.7 percent, character and behavior disorders; 1.1 percent, disorders of intelligence; and 6.6 percent, other psychiatric disorders (table 25 and chart 6).

Although this overall evaluation of the oversea theaters shows, in general, lower frequencies of neuropsychiatric disorders than in the con-

CHART 7.—*Admission rates for neuropsychiatric disorders, for selected areas, U.S. Army, 1944*

[Rate expressed as number of admissions per 1,000 mean strength per year]



tinental United States, it does not hold true when comparison is made in terms of combat versus noncombat areas.

Combat versus noncombat areas.—The broad effects of combat on the incidence of neuropsychiatric disorders are illustrated in chart 7, in which the 1944 admission rates are shown for selected areas. These effects are conspicuously brought out in comparing the admission rates of a noncombat area as the Alaskan Department, with those of a combat theater as represented by the European theater. Not only are the European rates generally higher, but they also increased tremendously with the advent of intensive combat. (Note the high rates of July and November, reaching a peak rate of about 70 per 1,000 mean strength per year. But even these rates are not representative of the actual incidence of neuropsychiatric conditions in combat, since a significant part of the theater strength is made up of noncombat troops. The average annual neuropsychiatric admission rates for combat divisions in the European theater were approximately 250 per 1,000 strength from June to November 1944. The problem is further discussed in subsequent sections dealing with individual theaters of operations.)

Discharges for Neuropsychiatric Disorders

During World War II, 389,000 persons were separated from the Army for neuropsychiatric disorders, of whom 375,000 were enlisted men discharged on certificates of disability for discharge. These separations represented 43.9 percent of all disability discharges (ch. IX, tables 2 and 4). In addition, 163,000 enlisted men were administratively discharged for inaptitude or unsuitability, and unfitness (ch. IX, table 11). The latter categories included separations for mental deficiency, homosexuality, enuresis, and certain other asocial and antisocial conditions for which, according to Army policy, administrative discharges were given. By combining all these (medical and nonmedical) separations, some 538,000 enlisted men were thus separated from the Army, for which the underlying cause of separation was basically psychiatric.

The principal cause of the neuropsychiatric separations for disability was psychoneurosis, constituting 69.1 percent of all neuropsychiatric discharges, or 79.8 percent of the discharges for psychiatric reasons. Next in order of magnitude was psychosis which accounted for 15.9 percent of all neuropsychiatric discharges, or 18.4 percent of the discharges for psychiatric reasons (table 26).

Table 27 shows the proportion of men discharged medically for neuropsychiatric disorders who had had oversea service. The proportion with oversea service among those discharged medically for all causes is included for comparison.

The limited data in table 27, relating to the distribution of discharges by percent with oversea service, clearly indicate that while the bulk of the discharges in 1943 and 1944 represented training casualties, the 1945 data show that most of the discharged personnel had oversea service, a large proportion of whom had undoubtedly combat service.

NEED FOR PREVENTIVE PSYCHIATRY

Defects in Preparation and Planning

As has been indicated already, psychiatric disorders proved to be a major source of manpower loss to the U.S. Army in World War II. At the beginning of the war, a potential loss of this magnitude was neither expected nor planned for by military authorities in general or the Medical Department in particular. In the Surgeon General's Office, although there was a large department of preventive medicine actively engaged in programs of disease prevention, there was no department of preventive psychiatry. It was not until February 1942 that a psychiatrist was assigned to the Surgeon General's Office, for any reason, and when assigned, his duties were concerned with hospital care and disposition of psychiatric cases rather than with the prevention of psychiatric disorders.

TABLE 26.—*Percent distribution of disability discharges for neuropsychiatric disorders, by diagnosis, U.S. Army, worldwide, 1942–45* [1]

Diagnosis	Total	Enlisted men
	Neuropsychiatric Disorders	
Neurological disorders:		
Epilepsy	3.9	3.9
Other	9.5	9.4
Total	13.4	13.3
Psychiatric disorders:		
Psychosis	15.9	16.0
Psychoneurosis	69.1	69.1
Character and behavior disorders	.8	.8
Disorders of intelligence	.7	.7
Other psychiatric disorders	.1	.1
Total	86.6	86.7
Total neuropsychiatric disorders	100.0	100.0
	Psychiatric Disorders	
Psychosis	18.4	18.4
Psychoneurosis	79.8	79.8
Character and behavior disorders	.9	.9
Disorders of intelligence	.8	.8
Other psychiatric disorders	.1	.1
Total psychiatric disorders	100.0	100.0

[1] Derived from table 2, chapter IX.

It was known that psychiatric disorders did occur in warfare, for the World War I experience showed some 106,000 admissions for neuropsychiatric conditions in the Army.[3] At the beginning of World War II, however, most military authorities and many psychiatrists, including civilian consultants to the armed services, believed that psychiatric disorders did not occur to a significant extent in "normal" persons, but arose primarily in the minority population who were "weaklings" or who had underlying emotional instability that predisposed them to psychiatric illness.

Admittedly, "psychotics," mental defectives, psychopaths, and severe psychoneurotics were untrainable, untreatable, disturbing to morale, and,

[3] The Medical Department of the United States Army in the World War. Statistics. Washington: Government Printing Office, 1925, vol. XV, pt. 2, table 46, p. 90. These admissions include the diagnoses listed under *"V. Nervous system, diseases of (all),"* and *"VI. Mental alienation"*; "alcoholism" and "drug addiction" are given under *"IV. General diseases (other)."* (See also appendix A, table 2, footnote.)

TABLE 27.—*Distribution of personnel discharged for neuropsychiatric conditions and for all medical conditions, by percent with oversea service*

Period	Discharge by percent with oversea service	
	Neuropsychiatric conditions	All medical conditions
1943 (May through December)	12	9
1944	35	33
1945 (January through June)	69	66

eventually, expensive liabilities to the Government. It was obvious that such persons were of no use to the service. An attempt should have been made to prevent them from being accepted, and when discovered in the Army, they should have been discharged. Also, it was believed that predisposition to psychiatric illness could be detected in advance. This belief led to the expectation that the psychiatric problem in the Army could be largely solved by establishing a screening process.[4] Accordingly, extensive arrangements were made to conduct a psychiatric screening examination on each candidate for military service. As previously stated, about 12 percent of the registrants examined in World War II were classified as IV–F for neuropsychiatric reasons, representing 38.2 percent of all disqualifications (appendix A, tables 5 and 7). In addition, procedures were established in training centers, medical installations, ports of embarkation, and elsewhere throughout the Army to detect and discharge those military personnel suffering with, or predisposed to, psychiatric disorders. In 1942, there were 22,000 psychiatric discharges for the entire year, but in September 1943, there were some 18,000 such discharges for that month alone —a rate of 216,000 discharges per year.

Lack of Experience and Methodology

However, even if the limitations of screening had been recognized and the full magnitude of the psychiatric problem foreseen, before World War II, no effective method for preventing psychiatric disorders was known which could have been used. Preventive psychiatry was then a new discipline, if indeed it could be said to have existed at all. Psychiatry had grown rapidly since World War I, and a great deal was known about the causes and nature of mental and emotional illness. However, this knowledge had been applied primarily to the treatment of the sick. Only the beginning of interest in the possibilities of using existing knowledge for prevention had occurred. It is true that a mental hygiene movement had been active for several decades, but this had concerned itself mainly

[4] Porter, W. C.: Military Psychiatrist at Work. Am. J. Psychiat. 98: 317–323, November 1941.

with standards of care in State hospitals for the insane, although the early treatment of minor psychiatric disorders in children and public education in the principles of mental health had been included in its activities.

The American Psychiatric Association, which represented the psychiatric profession as a whole in the United States, had no section devoted to preventive psychiatry, although it had sections concerned with almost every other aspect of mental illness. Similarly, medical schools and governmental agencies lacked departments of preventive psychiatry. The vast majority of civilian psychiatrists, before World War II, were involved almost exclusively with treatment and care, rather than with prevention, of psychiatric disorders. Consequently, when the fall of France and Pearl Harbor rather belatedly turned their attention to problems of military psychiatry (the 5-day program of the Annual Meeting of the American Psychiatric Association, in May 1942, allotted only a single afternoon to problems of military psychiatry), civilian psychiatrists concerned themselves principally with the problems of induction screening and treatment facilities in the Armed Forces and gave little consideration or encouragement to the development of a preventive program.

Failure of Screening

Not until the war had been in progress for a year and a half was it revealed that psychiatric cases were occurring in large numbers in the Army, despite the screening process. This delay in recognizing the failure of screening was due, in part, to the absence of pertinent and reliable statistical data. At the beginning of the war, the Medical Department had no effective system for obtaining regular reports on the number and types of mental disorders occurring among the troops. Data were available for the number of soldiers being discharged from the Army because of neuropsychiatric disorders, but there was no report on the number being admitted to hospitals. The only available source of information on psychiatric admissions was the WD MD Form No. 52 which was completed when patients were discharged from an Army hospital. Unfortunately, the Medical Statistics Division, SGO, was from 2 to 3 years behind in tabulating and processing statistical data from this source. The principal reporting system (WD MD Form No. 86ab, "Statistical Health Report") by which the Army kept abreast of the incidence of battle casualties, injury, and disease contained no place for reporting mental or nervous disease.

When, finally, a reporting system was established and data became available in the spring of 1943, they indicated for continental United States some 20,000 admissions for neuropsychiatric disorders per month, and this number climbed and reached a peak number of 31,000 in August of that year. The psychiatric problem looked very serious indeed. At the end of 1943, the data showed a total of 266,000 admissions in the continental United States. (See table 23 and chart 5.) Within the same year, 141,000

persons were discharged for neuropsychiatric conditions, constituting 40 percent of all medical discharges (ch. IX, tables 2 and 4).

Overseas, the situation was no better. During the last month of the Buna-Gona campaign, the neuropsychiatric admission rate was approximately 60 to 70 per 1,000 troops per year [5] from the entire Southwest Pacific Area, more than twice as high as the then current admission rate of troops in the United States and four times as high as the average neuropsychiatric admission rate for the American Expeditionary Forces during World War I. (The admission rate for neuropsychiatric disorders of the U.S. Army in Europe in World War I was 17.5 per 1,000 mean strength per year.) [6] Approximately 40 percent of all casualties being returned to the Zone of Interior from the Southwest Pacific Area were neuropsychiatric cases, as were also 42 percent of those from the South Pacific Area. The size of these losses was great enough to concern not only the Medical Department but also the military authorities.

Psychoneurosis

In the Surgeon General's Office, it was not fully appreciated that such large numbers of psychiatric casualties indicated that psychiatric screening had been useless. Mental defectives, severe psychopaths, and "psychotics" were still considered noneffective as soldiers and, therefore, not usable by the Army. The issue was, however, that such soldiers with severe overt problems were but a small portion of the total number of psychiatric cases being encountered. The vast majority were cases of psychoneurosis, which constituted almost all the psychiatric cases occurring in combat and most of those who were returned from oversea theaters. Similarly, most of the psychiatric cases admitted to hospitals from troops in continental United States were psychoneuroses.

Predisposition versus stress

Considerable evidence accumulated during the war which indicated that psychoneurosis occurred in a large proportion of soldiers whose past histories were negative for neuropathic traits or characteristics that could be taken to indicate "predisposition" to psychiatric disorders. In another significant percent of the cases, the histories showed varying degrees of past psychological disturbance; however, it was believed by the examining psychiatrists that the stress of the situation, rather than the weakness of the personality, was of more importance in having caused the presenting disorder.

The myth that only weaklings developed psychiatric disorders was finally exploded completely by reports from the North African theater,

[5] Personally collected data.

[6] The Medical Department of the United States Army in the World War, vol. XV, pt. 2, table 47, p. 115.

where a particularly careful study [7] had been made of the problem. It was found that in one campaign the incidence of psychiatric cases was uniformly higher among veteran combat troops than among fresh, inexperienced troops. Months of intensive combat had weeded out all the "weaklings." The men who remained had proved the toughness of their underlying personality structure by their mere survival. Yet fatigue and other factors produced more "psychoneurotics" in this group than in the fresh, untried troops. In short, it became evident that anyone could develop psychoneurosis under certain circumstances. The limitations of screening became obvious. If screening was to weed out anyone who might develop a psychiatric disorder, it would be necessary to weed out everyone.

Screening standards influence discharge standards

Psychiatric screening could weed out only abnormal men. It could not be expected to have any effect in decreasing the rate at which normal men broke down. It further ran the risk of eliminating men who, although having some defects of personality, nevertheless, if properly handled, could render valuable service in the Army. The assumption that a person developing a psychiatric disorder was a weakling led to the policy of discharging anyone who was labeled with a psychiatric diagnoses. The wastage inherent in this policy became evident when it was demonstrated in the North African theater that, if regarded as medical emergencies and properly treated, from 60 to 80 percent of the acute psychiatric casualties were recovered successfully for full combat duty.

Another unfavorable result of the liberal discharge policy soon became evident. Study of the psychiatric cases revealed that, although true malingering was rare, the escape mechanism, through utilizing symptoms of illness, was prominent and, frequently, very close to the conscious level. The policy of dicharging all psychiatric patients not only made the escape mechanism more effective and encouraged its use but also constituted a reward for sickness. Knowledge that the diagnosis of a psychiatric disorder led to prompt discharge from the Army became commonplace among troops and was an important stimulus in increasing the number of psychiatric admissions. To circumvent the escape mechanism and remove secondary gain from illness, it became evident that it might be necessary to retain, rather than discharge, known psychiatric noneffective personnel.

It should be recognized that this common statement of 60 to 80 percent successful return to full combat duty cannot be supported by followup studies which indicated that, while a majority of such returnees functioned effectively, there was a significant minority of 30 to 40 percent, similar to

[7] Annual Report, Neuropsychiatry Consultants Division, Office of The Surgeon General, U.S. Army, 1944, pp. 23–24.

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medical and surgical returnees, who were found to be noneffective in battle.[8]

Summary

It thus became clear that the psychiatric problem could not be solved by assuming that psychiatric cases represented weaklings who should not have been accepted by the Army in the first place. It had to be recognized that the various screening and elimination processes, although important, could hardly be called prevention. Prevention began where screening left off. It would be necessary to find out what was causing men to break down and then to attempt to eliminate those causes. The psychiatric problem involved not just the psychopaths, the psychotics, and the marginal segment of the Army; it involved the stresses and strains which affected the mental health of all personnel in the Army.

EPIDEMIOLOGY OF MILITARY PSYCHIATRIC DISORDERS

In seeking the causes of psychiatric disorders in the Army, it was possible to fall back on a considerable fund of existing knowledge of the etiology of psychiatric disorders in civilian life, plus some data on the causes of psychiatric disorders in warfare. From the work of Adolf Meyer and Sigmund Freud had grown the concept of mental health as the product of multiple factors, internal and external, operating upon a person throughout his lifespan. The experiences of World War I,[9] including the work of Thomas W. Salmon and Abram Kardiner and the memories of such psychiatrists as Arthur H. Ruggles, Frederick W. Parsons, and Edward A. Strecker, who had served in the Army in World War I, gave some glimpse of the application of this knowledge to the military scene.

Nature of Combat Stress

The application of certain principles of epidemiology was found to be useful. For example, when hospital admission rates were determined and studied, it was clear that, although the psychiatric problem was Army-wide, the rates were from 5 to 10 times as high among troops engaged in actual combat as in training centers, or in isolated oversea outposts, or anywhere else in the Army. This knowledge immediately lent perspective to the problem. The height of the rates in combat indicated the relative seriousness of manpower loss in combat. Obviously, priority needed to be given for further study of causes of these combat cases. It was epidemio-

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[8] (1) Combat Psychiatry. Bull. U.S. Army M. Dept. (Supp.) 9: 200–204, November 1949. (2) Glass, A. J.: Effectiveness of Forward Psychiatric Treatment. Bull. U.S. Army M. Dept. 7: 1034–1041, December 1947.

[9] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X.

logical studies of hospital admission rates which showed the direct role of physical danger of enemy shellfire in causing psychiatric disorders. Similarly, the steady increase in hospital admission rates with duration of exposure to enemy shellfire represented strong evidence of the role of physical exhaustion in these cases. Such studies were then confirmed by clinical examination of the individual cases.

One of the first and most influential of such studies was that of Capt. (later Maj.) Herbert Spiegel, MC,[10] a psychiatrist who had served as a battalion surgeon in an infantry division during the Tunisia Campaign in North Africa in 1942–43. He testified not only to the role of fear and fatigue in causing psychiatric disorders but asserted also that the morale of the men's immediate organization, the platoon or company, had a vital effect on their mental health; similarly, the quality of leadership, discipline, medical care, and basic motivation to fight were of utmost importance.

Report from Mediterranean theater

These findings were confirmed and amplified by a particularly able group of psychiatrists, serving combat troops during the subsequent campaigns in Sicily and Italy, under the leadership of Maj. (later Lt. Col.) Frederick R. Hanson, MC, the consultant in psychiatry to the Mediterranean theater surgeon. The key members of this group were Capt. (later Lt. Col.) Calvin S. Drayer, MC, Capt. (later Maj.) Alfred O. Ludwig, MC, Capt. (later Maj.) Louis L. Tureen, MC, Capt. (later Maj.) Stephen W. Ranson, MC, and Lt. (later Maj.) Albert J. Glass, MC. These men not only made the epidemiological and clinical studies which laid the groundwork for the development of preventive psychiatry in combat troops but also evolved the treatment program which later became the model for treatment of psychiatric disorders in combat throughout the Army, both in the subsequent campaigns in the European theater and in those in the Pacific areas. An early report made by Major Hanson based on the findings of these psychiatrists in the North African theater reads as follows:[11]

Precipitating Factors. The precipitating factors in the development of neurosis under battle conditions appear to be the following, listed in order of importance:

a. Length of battle trauma, that is, number of consecutive days in action.

b. Physical fatigue, due to improper sleep, prolonged exertion, irregular eating, weather, and intercurrent illness, e.g., mild dysentery.

c. Unit morale.

d. Explosions in close vicinity.

e. Observation of death and maiming of buddies.

f. Improper training and lack of confidence in unit leadership.

g. The frequently stated belief that "This is not our War."

It is important to note that, while cases occurring early in battle generally have an unstable background, those cases occurring later on generally (approximately 70

[10] Spiegel, H. X.: Psychiatric Observations in the Tunisian Campaign. Am. J. Orthopsychiat. 14: 381–385, 1944.

[11] Annual Report, Neuropsychiatry Consultants Division, 1944, pp. 11–14.

percent) have an essentially normal background and records. Furthermore, the percentage of psychiatric disability is higher among "veteran" troops of a unit than it is among replacements to that same unit. Among nonbattle neuropsychiatric casualties, the following precipitating causes are listed in the order of their importance:

a. Frustration in work and improper classification.
b. Domestic worries and separation from home.
c. Inability to adjust to difficult living conditions, such as poor quarters and food.
d. Air raids, especially in reclassified cases.
e. Long delays in replacement centers.
f. Prolonged and unnecessary hospitalization.

Attitudes and Beliefs in Enlisted Men and Officers. The following general beliefs and attitudes have frequently been noted in discussions with neuropsychiatric patients in Clearing Stations, Evacuation Hospitals, and in the special Neuropsychiatric Hospital:

a. That they have been expended without consideration for their rest and safety. One of the frequent complaints met with is that veteran troops were given insufficient rest after the Tunisian campaign.

b. That certain troops were doing all the fighting, particularly their own units. This belief was widespread among 1st Division men.

c. There was a deep seated conviction on the part of 1st Division men that they had been promised to be returned to the United States after the Tunisian campaign.

d. That places of recreation were not provided and existing places were put out of bounds in rest areas.

e. That PX supplies were not available in rest areas.

f. That they had frequently been fired on by their own artillery, bombed and strafed by their own planes.

g. That following the Tunisian campaign they did not receive recognition for their efforts, "heroic deeds." They noted this especially in the attitude of civilians of nearby communities.

h. A definite fear of replacement centers was frequently noted. The patients dreaded the uncertainty of placement, long periods of inactivity and the inability of replacement centers to handle their cases without undue delay.

i. Many patients entertained the belief that they had been improperly classified originally, and had not been given the work they were best suited to do.

j. That there was undue delay in being paid and delivery of mail.

k. Among officers the most common belief noted was that they had been improperly classified and were doing minor duties which could easily have been handled by officers of lower rank. In addition, recognition and promotions were not available as rewards for duties efficiently performed.

Morale:

a. Many men do not have a clear understanding of what they are fighting for. There is a definite lack of understanding concerning the whole situation and they do not know their role in the war.

b. They do not understand why they are sent overseas while millions of other soldiers remain in the United States.

c. Passive dependent trends have been fostered.

d. Rash promises have been made, or false rumors allowed to spread without denial, etc., that troops would be sent home after combat, especially in Tunisia.

e. There is frequently noted a lack of confidence in unit leadership.

Report from Pacific theaters

From the Pacific theaters came similar reports. For example, in the New Georgia campaign (July through September 1943), the psychiatric

problem proved to be especially serious in the early and most difficult stages of the campaign, principally in men with temporary symptoms precipitated by fatigue and emotional stress of jungle fighting. The problem was particularly grave in the 43d Infantry Division, involving almost 10 percent of its total strength during July 1943. A study of the records of these psychiatric casualties convinced Col. Clyde M. Hallam, MC, Surgeon, XIV Corps, that incompetent or questionable leadership in small units was operating as a major precipitating factor. The number of men evacuated from each company was found to be in direct proportion to the number of unit leaders evacuated. The analysis prepared by Colonel Hallam stressed the need which each soldier had for such orientation toward his task as only good leadership could provide, and also the importance of both good discipline and physical fitness.

Another report from a psychiatrist in the South Pacific Area reads as follows:[12]

> The ultimate goal of a very high percentage of personnel is to "get home," whether or not augmented by the thought "to get it over, and get home." Evacuation from an organization is one step to that goal. The overall problem of changing that goal from "to get home," to "win this War" or "to kill Japs" is a tremendous undertaking and involves changing of viewpoint in all ranks. It involves changing the trend of thinking even in the continental United States. Mail censorship indicates that mail from home does not promote the "win the war," "kill some Japs for me," "we're proud of you" note, but tends to increase nostalgia with the "wish you could be with us," "when are you coming home?" theme. Radio programs frequently carry the same note of nostalgic sentimentality. There is a preponderance of sentimental songs and love songs reaching popularity and being publicized and a dearth of good stimulating tunes such as marching songs for men to sing as they perform their duty. There is a great need for more education of the men by means of increased emphasis on orientation lectures. Greater emphasis should be placed on such types of moving pictures as "Divide and Conquer" and "Why We Fight." These latter are considered the best means at hand for education and orientation of the soldier, and their use should be extended and effort made to produce more of these films for showing to officer and soldier audiences. The soldier must know why he is fighting.
>
> Morale is directly in proportion to leadership; incidence of neuropsychiatric casualties is in inverse proportion to morale. Figures of neuropsychiatric casualties are high in units where the leader, be he of commissioned or noncommissioned grade, becomes a neuropsychiatric casualty. In units fighting side by side with this same unit, under the same conditions, be it squad, platoon, or company, in which leadership is good and the leader is not a psychiatric casualty, figures are disproportionately low. Good leadership is considered the most important factor in obtaining and maintaining morale. Continued emphasis is being placed on careful selection of leaders. Emphasis is also being placed upon building "esprit-de-corps" with the unit as a command function. This must be continually emphasized, as unit commanders are sometimes prone to consider morale building a function of Special Service, which is concerned primarily with recreation.
>
> However, it must also be said, that prolonged service outside the continental United States and in tropical and sub-tropical areas does have a deleterious effect upon some individuals. It is evidenced in this area by decreased vigor or drive, and increased census on sick call due to psychoneurosis and minor complaints of psychogenic origin.

[12] Annual Report, Neuropsychiatry Consultants Division, 1944, pp. 9–11.

Also related to reduce morale, as finely distinguished from "esprit-de-corps," has been a lack of replacement rotation policy to allow men who have been in this area for long periods, to be returned for duty in the continental United States. Allowing these men to remain in a unit until they become psychoneurotic breakdowns, and then evacuated, is not considered advisable. In the past, illness, plus return of small numbers of cadres, has been the only means by which a man could obtain his "goal" (return to the United States), and thus often illnesses are exaggerated, and the patient uncooperative in taking medication and treatment, in an attempt to be evacuated. It is believed that the recently approved rotation policy for this area, to be initiated in March 1944, will have a healthy and immediate effect. Establishing this method of return and giving the soldier "something to look forward to," will be a definitely beneficial morale factor, as well as a means of preventing psychoneurotic breakdown, and increasing unit efficiency.

Multiple Causation

From reports such as these, it became obvious that a number of factors were important in causing psychiatric disorders, both in combat and elsewhere in the Army. Personality structure was merely one of several. Danger, fatigue, leadership, morale, discipline, job assignment, motivation, training, domestic difficulties, and civilian attitudes—each of these might be as important as personality structure in any given case and in combination frequently more so. If psychiatric disorders were to be prevented, it would be necessary to control or modify any or all of these factors. If men were breaking down because they were inadequately motivated, then prevention would have to include means of giving them a clear understanding of the issues at stake in the war. If job assignment were playing a role, then it would be necessary to see if job classification and personnel placement could be improved from a psychiatric standpoint. Similarly, if leadership, morale, discipline, and training were important factors in mental health, then it would be the responsibility of psychiatrists to concern themselves with these problems also.

Reorientation and relocation.—To accomplish this mission in preventive psychiatry would require a radical change not only in the concept of the duties of a psychiatrist in the Army but also in the type of military unit to which he was assigned. In 1943, of the 1,300 psychiatrists in the Army, 957 were assigned to hospitals. Diagnosis, treatment, and disposal could be accomplished more efficiently in hospitals, but here psychiatrists came in contact only with troops who had already broken down. To prevent disorders from occurring, it would be necessary to move psychiatrists out of hospitals, even though they were urgently needed there, and to assign them to field units where they could come in contact with normal men on duty. Psychiatrists would then enter into the everyday life of the Army. If their recommendations concerning rest periods for combat troops, morale, leadership training, and job classification were not to be naive, it would be necessary for psychiatrists to acquire intimate knowledge of the

Army in all its aspects, particularly knowledge of the everyday problems of unit commanders.

Such a change would require a reorientation on the part of psychiatrists. But if they were to be accepted as useful advisers on leadership, discipline, morale, and personnel policy, a reorientation on the part of military authorities toward psychiatrists and psychiatry would also be required.

For troops in training in the United States, preventive psychiatry was best accomplished by placing psychiatrists on the staffs of the training center commanders with an organization which later came to be known as the Consultation Service. For combat troops, the key position for the psychiatrist was on the staff of the infantry, armored, or airborne division surgeon. At higher echelons, the key positions were on the staff of army, theater, or service command headquarters, and in the Surgeon General's Office.

APPLICATION IN ZONE OF INTERIOR

Early Development

The first beginnings of preventive psychiatry in the Army were made early in the war by psychiatrists at training camps in the Zone of Interior. The extramural activities of these psychiatrists were the basis for the later development of mental hygiene clinics, which became known as Training Center Consultation Services and were established at each of the approximately 30 basic training camps in the Army. The development and history of these Consultation Services has been described in chapter XIII.

It is true that, in their early days, operating under the Army's then current philosophy, the Consultation Services functioned primarily as psychiatric screens to eliminate "those mentally unstable individuals who are or who may become a distinct liability to military training, discipline and morale during the early weeks of training." [13] It was not until later in the war that the possibilities of this area of endeavor in preventive psychiatry were recognized and emphasis placed on it.

In the spring of 1942, several psychiatrists, independently and almost simultaneously, engaged in activities intended to prevent the occurrence of psychiatric disorders. The training camps where these psychiatrists were assigned were receiving large numbers of inductees, fresh from civilian life. It was here that the trainees received their first real contact with Army life, which included regimentation, Army discipline, and the physical and technical arduousness of the military training program.

The psychiatrists assigned to the camp station hospitals saw the inductees who failed in the training program, when these men were admitted

[13] Letter, The Adjutant General, to Commanding Generals, various Replacement Training Centers, 30 Oct. 1942, subject: Assignment of Neuropsychiatrists to Replacement Training Centers.

as psychiatric patients. Certain of these psychiatrists were alert enough to recognize that a large percentage of these cases represented little more than maladjustment to army life. It appeared to them that many patients could have become satisfactory soldiers if measures had been taken early to help them in their adjustment difficulties, before symptoms assumed a fixed pattern. Showing a considerable degree of resourcefulness, these psychiatrists, each in his own way, proceeded to leave the hospital environment, periodically, and observe the behavior of troops on duty. As long as psychiatrists remained in the hospital, little could be done in the way of prevention, since soldiers were not referred until they had become so maladjusted as to be considered sick. In each case, the psychiatrist gained permission from his superior to observe the trainees on the rifle range, on speed marches, at close order drill, and in battle indoctrination courses. Having thus gained a first hand view of the stresses to which the trainees were attempting to adjust, the psychiatrists proceeded to institute preventive measures.

Mental Hygiene Consultation Services

The activities of these hospital psychiatrists later developed into what were known as Mental Hygiene Consultation Services. They were, essentially, similar to mental hygiene clinics in civilian life, directed by a psychiatrist and staffed by psychologists, psychiatric social workers, other interviewers, and clerks. From an organizational viewpoint, the important feature of these clinics was that they were disassociated from the camp hospital, both geographically and administratively, and were attached instead to the training center headquarters. In this way, they became identified with the viewpoint of troop commanders instead of the hospital atmosphere.

The psychiatrists lived in daily contact with the headquarters staff and with troops in the field. They became known personally not as "nut doctors," but as knowledgeable members of the training staff, often providing practical suggestions which were found to be of help in solving personnel and morale problems. In performing their duties, the psychiatrists became acquainted with the daily aspects of camp life. They knew what it was like to go on a 12-mile "speed march," and the psychological adjustment required to function effectively in the rifle range became a matter of personal experience. Many of the psychiatrists actually qualified as marksmen, not only with rifles but also with light and heavy machine-guns.

Screening function

As mentioned previously, in their inception and early function, these Mental Hygiene Consultation Services were primarily psychiatric screens

to catch the mental defectives and the emotionally unstable who had not been rejected at the induction stations. For the first 18 months of their existence, the Consultation Services were considered of value chiefly for this screening function. Training center commanders welcomed any organization which would serve as a means of expeditiously eliminating the seemingly never ending supply of men who were not sick enough to be discharged medically by the hospitals, but who were apparently unable to complete the training program and, consequently, were a constant source of administrative difficulty. Indeed, the Mental Hygiene Consultation Services were kept so busy with diagnosing and administratively disposing of these marginal personnel that it was difficult to find time for even minimal treatment of patients, let alone for any considerable program of prevention. Some of the services saw as many as 1,000 persons a month, the average being from 300 to 600 a month, and even with a staff of interviewers and other assistants, it was evident that a single psychiatrist at any one clinic had his hands full even examining the clinical records of all cases.

In specifying the mission of the Consultation Services when they were initially established in the various training centers, the official directive [14] stressed their screening function. Emphasis was also placed on giving early treatment of "those normal individuals who may have correctable maladjustment to the Army Service." However, no mention was made of preventive psychiatry per se in this letter, except for the statement that the training center psychiatrist was to "develop a liaison with line and medical officers for the purpose of instructing and developing a better understanding of the principles of mental hygiene as applied to the military service (and) to aid in the morale program of the stations (camps) by the use of neuropsychiatrists' specialized training and knowledge."

Preventive psychiatry initiated

An attempt to emphasize the preventive aspect of the training center psychiatrist's duties was made in the summer of 1943. Then, a letter was sent out over The Surgeon General's signature to each of the training center psychiatrists, drawing their attention to the existence of the Special Services Division (later renamed the Information and Education Division), Army Service Forces, and informing them of the liaison with this division which had been made by the Neuropsychiatric Branch of the Surgeon General's Office. In this letter, The Surgeon General also instructed the psychiatrists to effect a similar liaison with the Information and Education organizations in their own training centers.

Again, in the fall of 1943, eight of the training center psychiatrists who had been most active in pursuing preventive measures were called

[14] See footnote 13, p. 397.

into Washington, D.C., by the chief of the Mental Hygiene Branch, Neuropsychiatry Consultants Division, for a conference. Ways and means of pursuing preventive psychiatry were discussed, and representatives of the Information and Education Division were brought in to describe their facilities and activities concerning morale and motivation through orientation and information programs. Although this conference stimulated interest and clarified methods to some extent, it was evident that the training center psychiatrists were so overburdened with the load of screening and disposal that not a great deal of headway in prevention could be expected.

It was not until the late fall of 1943 and the spring of 1944, with the reversal of Army policy from screening to conservation of manpower, that the training center psychiatrists were able to function effectively in preventive psychiatry. As long as the Army policy was to get rid of noneffective or marginal personnel, the training center psychiatrist could really do very little else. When, however, the Army reversed its policy and made it perfectly clear that, henceforth, manpower must not be wasted but must be conserved and utilized at any cost, then Army commanders gradually began to view psychiatrists in an entirely new light. Instead of being utilized mainly for disposition of personnel, psychiatrists were found to be of value as sources of advice for effectively utilizing marginal personnel.

Gradually, commanders began more and more to turn to their psychiatrists for advice on problems of personnel, morale, discipline, AWOL (absent without leave), and training schedules. The process was helped by War Department Circular No. 48, issued on 3 February 1944, which specified the commander's responsibility for developing the mental health of trainees and officially designated the mental hygiene lectures to be given to officers and enlisted men by psychiatrists at all training camps.

Elevation of psychiatry, late in 1943, to a division on a level with surgery and medicine in the Surgeon General's Office gave increased standing and prestige to the training center psychiatrists. It was shortly thereafter that Lt. Col. (later Brig. Gen.) William C. Menninger's leadership began to be felt in the field. A full-time supervisor for the Mental Hygiene Branch, Maj. (later Lt. Col.) Manfred S. Guttmacher, MC, was appointed to the Surgeon General's Office in the spring of 1944. His regular inspection of all the Mental Hygiene Consultation Services not only increased the general efficiency of their operations, thus freeing time of personnel for preventive work, but also established Major Guttmacher's status as a representative from Washington, enabling him to accomplish a great deal in interpreting to the local commanders the current and potential function of the psychiatric services. Further recognition came to training center psychiatrists as a result of a request in the spring of 1944 by the Office of the Secretary of War that they study the training programs in all basic training centers in the country and recommend measures for their improve-

ment from a psychiatric viewpoint. The consolidated report [15] of these studies, covering such subjects as leadership, training methods, and orientation, was widely read by training center commanders and their staffs. This report impressed them both with the psychiatrists' practical insight into personnel training problems and with the fact that higher authority was interested in psychiatrists' opinions on these subjects.

Preventive psychiatry officially established

At the end of a 3-day conference of all the Mental Hygiene Consultation Service psychiatrists held at Aberdeen Proving Ground, Aberdeen, Md., in January 1945, the general consensus [16] was as follows:

> Whereas the treatment and disposition of individuals suffering from psychiatric disorders must be continued, it is evident that the chief military value of a training center psychiatrist can be in the prevention of psychiatric disorders. * * * At the present time, limitation of assisting personnel barely permits the psychiatrist time to handle his heavy caseload of treatment and disposition. Assumption of duties in regard to prevention must be gradual and depend upon the possibility of adding further trained personnel to the consultation staff.

Representatives of both the Army Ground Forces and Army Service Forces were present at this conference, and shortly thereafter, the responsibility of mental hygiene clinics for preventive psychiatry was, for the first time, stated specifically in official directives issued by Army Service Forces and Army Ground Forces headquarters. Also, in WD Circular No. 81, dated 13 March 1945, the training center psychiatrist's position as a staff officer to advise command on policy and procedure concerned with mental health was clearly authorized.

Hospital Psychiatrists

As mentioned previously, psychiatrists in hospitals were not in a position to function effectively in preventive psychiatry. They were too far away from the scene of action, so to speak, and were concerned mainly with problems of treatment and disposition. This was particularly true of the general hospitals, both in the Zone of Interior and overseas. Station hospital psychiatrists, in certain instances, did come to have some contact with troops in training and, occasionally, did give the mental hygiene lectures prescribed for by WD Circular No. 48. Actually, had these psychiatrists been given adequate assistance, they could have done more in preventive psychiatry than they did.

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[15] The full text of this report is given in chapter XIII, pages 357–359.—A. J. G.

[16] Annual Report, Neuropsychiatry Consultants Division, 1945, exhibit B thereto.

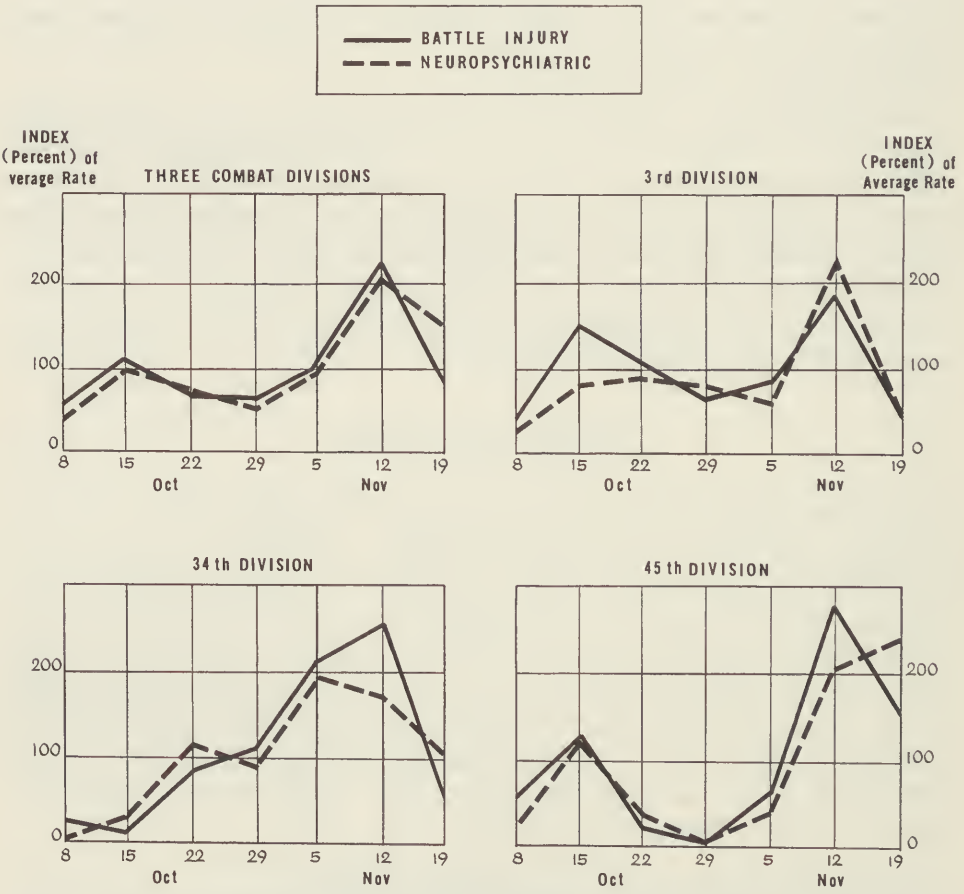
PREVENTIVE PSYCHIATRY IN COMBAT THEATERS

Combat Stress and Psychiatric Breakdown

The incidence of psychiatric disorders was intimately related to the intensity of combat. In chart 8, the rates for battle injuries and psychiatric casualties among three infantry divisions have been compared in index form, for a 7-week period of combat. The rates have been expressed as index numbers, having as a base the average rate for the period in each case. This was done to facilitate comparison of the two sets of rates which, of course, are of different magnitude.

The direct relationship is evident. The rate of battle injuries which is presumed to be an index of intensity of combat is shown by this chart

CHART 8.—*Relation between trend of battle injury and neuropsychiatric admissions, selected divisions, Fifth U.S. Army*



Source: Annual Report, Neuropsychiatry Consultants Division, Surgeon General's Office, 1944, p. 26.

to have a remarkably direct relationship with the rate of psychiatric casualties. Roughly, one psychiatric casualty to four or five wounded in action prevailed in troops in combat. Admission rates of infantry (or armored) divisions in combat, although of a high order, were still, as already indicated, not fully representative of the effects of combat, since even in combat divisions only men engaged in frontline duties, such as riflemen, were exposed to continuous and high degree of danger. In infantry battalions, where a much higher proportion of the men were directly exposed to combat, psychiatric admission rates as high as 1,600 to 2,000 per 1,000 troops per year [17] were observed in some instances for short periods.

The "breaking point"

These rates were so high as to indicate that the breaking point of the average man was being reached. In many circumstances, particularly in the prolonged campaigns of the Mediterranean theater, most men exposed, beyond a certain point in time, to frontline combat, ultimately broke down psychologically, or would have done so had they not been killed, wounded, or otherwise disabled.

Mediterranean theater.—One of the first studies [18] suggested that the breaking point of most men was in the range of 200 aggregate days of frontline combat exposure. The study was based upon the clinical and epidemiological findings of key psychiatrists in the North African (later the Mediterranean) theater, as follows:

> The key to an understanding of the psychiatric problem is the simple fact that danger of being killed imposes a strain so great that it causes men to break down. This fact is frequently not appreciated and cannot be fully understood until one has either seen psychiatric cases just out of the lines or himself has actually been exposed to bombing, shell and mortar fire. One look at the shrunken, apathetic faces of psychiatric patients as they come stumbling into the medical station sobbing, trembling, referring shuddering to "them shells" and to buddies mutilated or dead is enough to convince most observers. Anyone entering the combat zone undergoes a profound emotional change which cannot be described. Each man "up there" knows that at any moment he may be killed, a fact kept constantly before his mind by the sight of dead and mutilated buddies around him. To one who has been "up there" it is obvious that there is no such thing as "getting used to combat." Each moment of it imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus, psychiatric casualties are as inevitable as gunshot or shrapnel wounds in warfare. Prevention can be thought of only in terms of preventing needless waste of manpower. All other "causes" of psychiatric disorders must be thought of only as factors which weaken a man's resistance to the single important cause, namely danger.
>
> Of all branches, the infantry is most affected by danger. Battle casualty rates are so much higher in rifle battalions than in any other type of ground unit

[17] Personally collected data.

[18] Memorandum, The Surgeon General, for the Assistant Chief of Staff for G–3, (through: Commanding General, ASF), 16 Sept. 1944, subject: Prevention of Manpower Loss From Psychiatric Disorders.

that these troops should be considered as a separate group just as are flying combat personnel in the air force. For this reason, the loss of manpower from psychiatric cases is also highest in infantry units. In the North African theater during the Tunisian, Sicilian and Italian campaigns, neuropsychiatric casualty rates of 1,200–1,500 per 1,000 strength per year have not been uncommon in rifle battalions, whereas in corresponding units of all other types, including artillery, engineers, rear area and service troops, rates above 20–30 were rarely encountered. In general, 15–25 percent of the total nonfatal combat casualties were neuropsychiatric.

Of more significance, however, is that in the North African theater practically all men in rifle battalions not otherwise disabled ultimately became psychiatric casualties. Although only 1–3 percent of the combat strength was lost from this cause during any single offensive, apparently the intensity and duration of the continued campaign were such that the limit of endurance of the average soldier was reached. Just as a 2½-ton truck becomes worn out after 14,000–15,000 miles, it appears that the doughboy became worn out; he either developed a frankly incapacitating acute neurosis or else became so hypersensitive to shellfire, overly cautious and jittery, that he was ineffective and demoralizing to the newer men.

The point at which this occurred has not been clearly established, but it appears to have been in the region of 200–240 aggregate combat days. The number of men still on duty after this is small and their value to the unit negligible. The first indication of this appeared in the clearing station of the old divisions (the 3d, 34th, 36th, and 45th Infantry Divisions) and the 601st Clearing Company, which handled all psychiatric cases evacuated in the Fifth Army. From the Sicilian Campaign onward, it was noted that an increasing number of the psychiatric patients being sent back from the lines were not weaklings who had merely broken down after a short exposure to combat, but experienced veterans, strong men with excellent combat records, often including decorations. Most of them were noncommissioned officers: squad, section, and platoon leaders. By the spring of 1944, following the Volturno, Rapido, and Cassino actions, more of these old men than new men were coming in as psychiatric patients. Finally, the statements begin to be heard: "I'm the last old man left in my platoon." "There's only two of us old men left, and they're no better off than I am. You'll be seeing them soon." The frequency of these statements made it difficult to doubt their credibility.

In the light of these findings it was decided to investigate the matter further. Accordingly, a survey was made of Battalion and Regimental Surgeons, of Division Psychiatrists and experienced combat unit commanders. Particular emphasis was placed on obtaining the opinion of company grade commanders, since they had the most direct contact with troops. It was found that both the medical and line officers were in unanimous agreement that, by the time a man had served 200–240 aggregate days of combat in a rifle battalion, he was noneffective. He was worn out. If he hadn't frankly "cracked-up," he was so jittery under shellfire and overly cautious that in addition to being noneffective he was a demoralizing influence on the newer men. Actually, many of the line officers were emphatic in stating that the limit of the average soldier was considerably less than 200–240 aggregate combat days. Most men were noneffective after 180 or even 140 days. The general consensus was that a man reached his peak of effectiveness in the first 90 days of combat—after this his efficiency began to fall off and from this time he became steadily less valuable until he finally was useless. They agreed that actions such as the Rapido and Cassino accelerated this process, that men who had survived these actions were never the same again. They stated, however, that even relatively light successful actions such as were experienced by certain units in the Rome push cannot be considered light in their effect on the infantryman.

Individuals developing psychiatric disorders after less than 200 combat days can and have been successfully returned to full combat duty by the excellent frontline

treatment developed in the North African theater. The "worn out" soldier on the other hand is through. At least 6 months would be required to make him effective again for combat though he still may be very useful in noncombat assignment.

The "life" of the average infantryman before he wears out and becomes noneffective appears to depend to a great extent on how continuously he is used. The British, for instance, estimate their riflemen as good for 400 aggregate combat days, a period almost twice as long as ours. This difference they attribute to the policy of never keeping infantrymen on the line more than 12 days at a stretch, alternating 4 days rest with each 12 days combat. The American doughboy, on the other hand, was usually kept in 20–30 days, frequently 30–40 and occasionally as high as 80 days without relief. This has been necessitated by tactical requirements although the fact that a man wears out under combat has perhaps been incompletely recognized by the command.

European theater.—Another study based on experience in the European theater gave similar results: [19]

It was found that after 4 months of continuous combat, riflemen and particularly key noncommissioned officers, through the process of normal wear and tear began to exhibit less initiative, lower efficiency, and decreased ability to lead troops into battle. This was even more marked at the end of 6 months of combat. Several divisions found that only 3 percent of the riflemen who had been in combat for 180 days still remained in the division. Those who did remain were key men and, in general, repeatedly decorated. These divisions estimated that half of this group had become useless for combat in the same manner that equipment may be worn out to the extent that it is of no further service.

Statistical analysis.—Beebe and Appel,[20] after the war, made a study based upon the individual records of 2,500 frontline infantrymen selected on a sample basis from all the principal infantry divisions committed in the Mediterranean and European theaters. They found that, for each aggregate 10 days of frontline combat, from 3 to 10 percent of the men who still remained on duty broke down and were admitted to the hospital. At these rates, the breaking point of the average soldier was estimated to have been in the range of 80 to 90 aggregate days of combat. None of the 50 infantry companies studied in the Mediterranean theater had less than 90 aggregate days of combat, which corresponds to the point at which about half of the men would be expected to have broken down. Half of the companies studied had more than 131 aggregate days of combat, and at this point on the stress scale, an estimated 70 percent of men would have broken down. An estimate developed for all infantry rifle companies which had been committed in the Mediterranean theater suggested that half had 85 or more aggregate days of combat; by day 85 on the company combat scale, almost half of the men would have broken down, according to the calculations made. The answer seems plain then, that in the campaigns of the Mediterranean theater there were many company size combat units from which half or more of the personnel would have become psy-

[19] After Action Report, Third U.S. Army, 1 August 1944–9 May 1945.

[20] Beebe, G. W., and Appel, J. W.: Variation in Psychological Tolerance to Ground Combat in World War II. Final Report, Contract DA–49–007–MD–172, for Medical Research and Development Board, Office of The Surgeon General, 10 Apr. 1958.

chiatric casualties had not so many emerged as battle casualties or as nonbattle casualties due to injury or disease.

Nonbattle Stress and Psychiatric Breakdown

Southwest Pacific Area

It was not only combat per se which caused high neuropsychiatric rates in World War II. This is readily appreciated from table 28 and chart 9 which compare admission rates in 1944 by theaters of operations. The Southwest Pacific Area especially illustrates the complexity of the problem. Although combat in this area was by far less intense during this time than in the Mediterrean theater (as evidenced by the admission rates for battle injuries), the admission rates for neuropsychiatric disorders were relatively higher in the Southwest Pacific Area than in the Mediterranean theater. While it is believed that the prolonged combat and deficiency of motivation were the primary factors in the higher neuropsychiatric incidence in oversea theaters, there were other factors which were also related. Causal factors which stand out in the Southwest Pacific

CHART 9.—*Admissions for battle injuries and neuropsychiatric conditions, World War I and World War II (1944), by theaters of operations*

[Rate expressed as number of admissions per 1,000 mean strength per year]

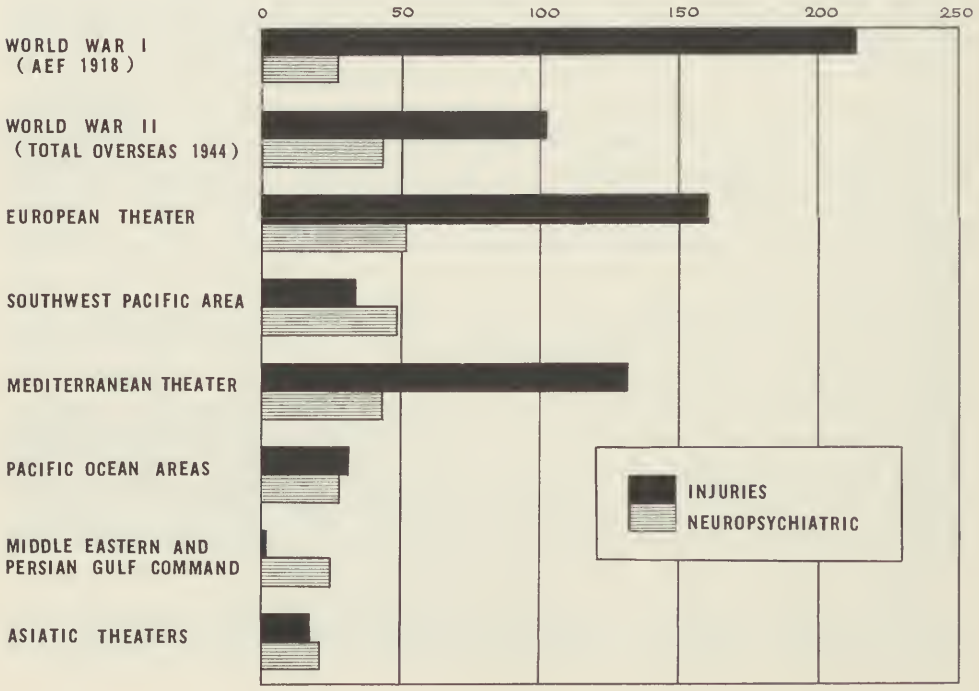


TABLE 28.—*Admissions for battle injuries and neuropsychiatric conditions, World War I and World War II (1944), by theaters of operations*

[Rate expressed as number of admissions per 1,000 mean strength per year]

Period and theater of operations	Battle injuries	Neuropsychiatric conditions
World War I	[1] 214	[2] 26
World War II (1944): [3]		
European theater	160	52
Southwest Pacific Area	34	48
Mediterranean theater	131	43
Pacific Ocean Area	31	27
Middle East and Persian Gulf Command	1	25
China-Burma-India theater	18	20
Total	102	43

[1] The Medical Department of the United States Army in the World War. Statistics. Washington: Government Printing Office, 1925, vol. XV, pt. 2, table 105, p. 1017.

[2] The Medical Department of the United States Army in the World War, vol. XV, table 47, p. 114.

[3] "Morbidity and Mortality in the United States Army, 1940–1945," Medical Statistics Division, Office of The Surgeon General, 1948.

Area were the tropical climate, lack of normal social and cultural environment, monotony of the jungles, and lack of adequate rotation policy. In addition, the large numbers of troops in base areas who were not fully occupied felt a sense of purposelessness in their sacrifices.

Far East Air Forces

The deleterious effect of such environmental conditions on the efficiency of personnel is further illustrated by the data in table 29, relating to Far East Air Forces; namely, the 38th Bombardment Group. These data clearly indicate the enormous increase in medical care and in the increasing loss of man-days with increasing length of service. (Compare, especially, the indexes of morbidity between "under 18 months" and "over 18 months" length of service.)

A comment [21] on the data just cited was as follows:

> Figures similar to these would hold true for practically every Air Force unit with a similar length of service in the forward area. Unit surgeons have utilized every possible means to convey this information to higher headquarters: Sanitary reports, special reports, and subject letters, and this material has been transmitted from this Headquarters in reports of Essential Technical Medical Data and by a special report of the operations analysis section.
>
> It is believed that these important figures dealing with a situation closely related to the problems of morale, neuropsychiatric disease and operational efficiency should be considered of sufficient importance for transmission to The Adjutant General.

[21] Essential Technical Medical Data, Far East Air Forces, for January 1945, dated 1 Mar. 1945.

TABLE 29.—*Indexes of morbidity, by length of foreign service* [1]

Index of morbidity	Sick days per 100 men, by length of service			
	6 to 9 months	15 to 18 months	Under 18 months	Over 18 months
On sick call	30.5	46.1	33.6	78.2
Sick in quarters	17.3	5.8	15.0	11.2
Sick in hospital	51.2	94.2	59.9	91.5
Total	99.0	146.2	108.5	180.9

[1] Derived from data in: "Essential Technical Medical Data, Far East Air Forces, for May 1944, dated 15 July 1944." "Under 18 months" included 516 men: 410 men with 6 to 9 months, 2 men with 10 to 14 months, and 104 men with 15 to 18 months of service. "Over 18 months" included 518 men.

Division Psychiatrists

It was not until the late fall of 1943, after reports had been received from the Tunisia and Buna Gona Campaigns, showing the seriousness of psychiatric casualties as cause of manpower loss in combat, that authorization [22] was finally obtained to assign one psychiatrist to each combat division. This represented the most important organization for preventive psychiatry since it was in combat divisions that the highest rate of psychiatric casualties occurred.

Instruction in preventive psychiatry

It is true that the primary purpose in assigning psychiatrists to divisions was to insure prompt treatment of casualties and to "maintain a constant screening process for the purpose of detecting and promptly eliminating individuals emotionally unfit for military service." However, the official statement of the duties of the division psychiatrist, as contained in WD Circular No. 290, specified:

> Not only is he to screen out the mentally unfit, but to make available his professional knowledge for the everyday problems of discipline and morale. * * * advise in all matters pertaining to the mental health of the command * * * assist in the program of preventive psychiatry, especially in its relationship to discipline and morale, through educational programs and informal discussions with line officers and others who may seek his advice. * * * help in the proper assignment of military personnel, and keep * * * constantly oriented to the changing psychiatric problems during the training, pre-combat and combat periods, with a view toward the development of the mental toughness essential to combat troops.

In a 3-day conference held in Washington, D.C., in November 1943, to instruct 60 newly appointed division psychiatrists in their duties, considerable emphasis was placed on preventive psychiatry, although here,

[22] War Department Circular No. 290, 9 Nov. 1943.

also, the primary function was seen to be in treatment and screening. The conference program included an hour's presentation, on prevention, by the chief of the Mental Hygiene Branch, Neuropsychiatry Consultants Division. One of the more experienced training center mental hygiene psychiatrists presented a talk on "Psychiatrists' Relationship With Line Officers." Maj. Gen. Howard McC. Snyder, from the Inspector General's Office, emphasized the need for division psychiatrists to attempt to conserve manpower as well as to screen out misfits. An entire afternoon of the conference was devoted to a presentation of the work of the Morale Services Division, ASF, on ideological and informational programs as it pertained to mental health. Maj. (later Lt. Col.) Frederick R. Hanson, MC, fresh from the battlefields of North Africa and Sicily took a prominent part in the proceedings and was able to impress the group of the urgent need for, and the practical applicability of, preventive psychiatry in combat.

Evolution of preventive psychiatry

Although the duties of division psychiatrists concerning prevention were thus fairly clearly specified officially, a great many of these officers found, on reporting for duty at their division headquarters, that their mission in this regard was not clearly understood nor sympathetically received either by the division surgeons who were their immediate superiors or by the division commanders and their staffs. Psychiatrists, here, as in the training camps in the early days of the war, were viewed with suspicion and resentment. They were considered "nut pickers" who properly belonged in lunatic asylums with their patients and had no proper place in a fighting outfit composed of "redblooded" American soldiers. Many psychiatrists had a long uphill struggle in this regard and, not infrequently, were forced to work as general medical officers, leaving psychiatry functions for shorter or longer periods.

As the divisions entered combat, however, and psychiatric cases began to pour into the aid stations by the hundreds, sometimes even by the thousands, the picture changed rapidly. Psychiatrists came to have a real place on the fighting team. They were looked upon not merely as a means of providing skilled treatment to mentally sick men, but also as a source of urgently needed advice on how to prevent this manpower loss. They became known personally to the responsible regimental and battalion commanders, frequently worked closely with the division personnel section (G–1), with the Judge Advocate General's Office, with the Information and Education Office, and in many divisions conferred regularly with the chief of staff, and, sometimes, with the commanding general of the division.

The division psychiatrist's work in this regard was hindered by the fact that although he was on the division surgeon's staff, and thus in a staff position, by tradition and practice, particularly during combat, he

functioned at the division clearing station in the treatment of patients. It was not customary in the Army for medical officers to both treat patients and function at an advisory policy level which was required in preventive activities. War Department Circular No. 81, however, which was issued in March 1945, stated specifically that, in divisions as well as in training centers, psychiatrists were to be "regarded as having a staff function in advising the command on policies and procedures which affect mental health and morale."

Formal establishment of preventive psychiatry

In the final statement of the division psychiatrist's duties, written to incorporate the lessons learned during the course of the war and issued on 28 June 1946 as Changes No. 1 to WD Medical Field Manual 8–10, his status as a staff officer was made quite clear and his responsibilities for preventive psychiatry set forth specifically:

> The division neuropsychiatrist is assigned to the staff of the Division Surgeon. He has a dual function. As a staff officer he assists the surgeon in advising command on matters of policy and procedure which affect the mental health and morale of troops. As a professional consultant he supervises and assists in the treatment and disposition of neuropsychiatric disorders occurring within the division.
>
> 1. *Prevention.* The division neuropsychiatrist keeps constantly informed on all matters which affect the mental health of the troops and takes such action as is indicated to correct conditions that have an adverse effect in this regard.
>
> (a) Since the majority of the factors which determine mental health of troops fall within province of command, the main job of preventive neuropsychiatry must be done by commanding officers of the line. The division neuropsychiatrist acts as a source of professional neuropsychiatric knowledge on this problem. He will maintain close liaison with responsible officers of the regimental and division commands, cooperate closely with personnel officers concerning matters of assignment, consult with the judge advocate in regard to medicolegal problems, cooperate closely with and assist other agencies important to the mental health of troops: the information and education officer, the Red Cross, the special services officer, and the chaplain.
>
> (b) To keep informed on matters affecting mental health he will continually study the current attitudes and morale of divisional personnel, and the psychological stresses to which divisional personnel are exposed, both in and out of combat. He should follow closely such matters as training schedules, furlough policies, disciplinary procedures, need and opportunity for rest and recreation.
>
> (c) He will conduct a continuous educational program by formal lecture and informal discussion designed to instruct enlisted personnel in the principles of mental hygiene and officers in the maintenance of mental health of troops.
>
> * * * * * * *
>
> He will maintain adequate current records pertaining to the mental health of the command. During combat he will keep informed as to the incidence of neuropsychiatric disorders in all units of the division in order that he may be able to advise the surgeon and command as to preventive measures that may be indicated. He will prepare such reports as are required by higher authority.

Hospital Psychiatrists

Of all hospital psychiatrists in oversea theaters, those who did the most preventive psychiatry were in the "Exhaustion Centers" which functioned in the Army zone just behind the combat divisions. These psychiatrists frequently were able to maintain close contact with the division psychiatrists, whose cases they received, and to keep tight the evacuation screen which was so important in preventing epidemics of combat psychiatric disorders. When too many cases were being received from one division, they were able to bring this to the attention of both the Army consultant in psychiatry and the division concerned, so that steps could be taken to remedy the situation. In certain exhaustion centers, other preventive measures were taken. For example, in February 1944, the group of psychiatrists[23] in the 601st Clearing Company, Separate, 1st Platoon, serving as the exhaustion center of the Fifth U.S. Army, in Italy, submitted a report to the Surgeon, Fifth U.S. Army, recommending as preventive measures that infantry replacements be sent forward in groups who had been trained together rather than as individuals. They also pointed out that faulty leadership, excessive periods of duty in battle, and lack of training of infantry replacements were important causes of psychiatric casualties. It is evident that exhaustion center psychiatrists under the field Army headquarters could have done a great deal more along this line if their role in preventive psychiatry had been officially recognized and encouraged and if they had learned more of the skills necessary for staff work.

Theater and Army Consultants

By the end of the war, psychiatrists were on duty as consultants in each major oversea theater and in all but one of the armies. These were key positions, from an organizational standpoint, for the prevention of psychiatric disorders. For the most part, however, these men were so occupied with the supervision and administration of hospitalization and disposition of psychiatric casualties that they had little time for practicing preventive psychiatry. It is also generally true that the possibilities and responsibilities for preventive activities were not so clearly recognized either by these psychiatrists or by their headquarters, as were their functions in other respects.

Theater consultants

Preventive measures were attempted to some extent by several of the theater consultants. As early as the late fall of 1943, Major Hanson, the psychiatric consultant in the Mediterranean theater, submitted a

[23] Capt. (later Lt. Col.) Calvin S. Drayer, Capt. (later Maj.) Stephen W. Ranson, Capt. (later Maj.) Alfred O. Ludwig, and Capt. (later Maj.) Walter L. Ford.

memorandum which called attention of the high command to the direct relationship between the rate of psychiatric casualties and the length of time infantrymen were kept in the line without rest. Later, Major Hanson attempted, although unsuccessfully, to have a preventive psychiatry section with adequate personnel set up as such in the theater surgeon's office.

Col. Lloyd J. Thompson, MC, Consultant in Psychiatry in the European theater, also submitted several memoranda recommending preventive measures involving replacement policies, training, rehabilitation, rest periods, and the like, to his theater command headquarters.

Similarly, Lt. Col. (later Col.) M. Ralph Kaufman, MC, Consultant in Psychiatry in the South Pacific Area, made attempts to study the morale and attitudinal factors producing psychiatric casualties in base areas among combat troops and to recommend the measures necessary for their modification.

Army consultants

Compared to the oversea theater consultants, the field army consultants in psychiatry were in a particularly advantageous position to pursue preventive psychiatry. They were free of the time-consuming difficulties inherent in supervising the large rear area general and station hospital neuropsychiatric services. They were recognized as staff officers of the Army headquarters with a voice in the Army's policy; still, they were close to the scene of action. Frequently, they were able to visit the various ongoing field and combat activities and to observe the factors which were producing psychiatric casualties. The degree to which the psychiatrists in these positions actually functioned to prevent psychiatric disorders varied considerably in the different field armies; much depended upon the individual psychiatrist's own interest and vision, in this respect, as well as upon the encouragement he received from his immediate superiors. It is probably true that, when these officers were first assigned as Army consultants in psychiatry, few of them recognized their potential role in the prevention of psychiatric disorders, and no formal instructions in this respect were issued either by Army or theater headquarters or by the War Department.

An example of the type of preventive activities engaged in by Army psychiatric consultants was furnished by Lt. Col. (later Col.) William Srodes, MC, Consultant in Neuropsychiatry, First U.S. Army. Colonel Srodes, in 1944, was instrumental in having army and corps rest camps established for combat troops and, also, in having a policy adopted for the routine sending of men to these camps. He made certain that the rest policy pertained to battalion commanders and company grade officers as well as to enlisted men. When, in July 1944, one of the combat divisions (90th Division) was in a state of low morale, Colonel Srodes induced the "Stars and Stripes" to give the division "a big play and buildup." He

maintained close liaison with the Army Quartermaster General to insure that frontline troops in the First U.S. Army obtained shoepacks, overcoats, ponchos, and other supplies essential for their morale as well as for their well-being. The division psychiatrists in the First U.S. Army, as a result of Colonel Srodes' leadership, were particularly active in preventive psychiatry.

In the Fifth U.S. Army, as a result of the neuropsychiatry consultant's efforts, Lt. Gen. Lucian K. Truscott, Jr., the commanding general, personally attended a conference with the division and evacuation hospital psychiatrists to discuss leadership, AWOL, discipline, and problems allied to psychiatric casualties. From the mutual understanding that developed as a result of this conference, it is evident that much more could have been done in this line of endeavor by Army psychiatric consultants had the possibilities for such efforts in preventive psychiatry been earlier recognized and encouraged.

ARMY AUTHORITIES AND PSYCHIATRY

The attitude of Army authorities toward psychiatry changed during the course of the war. The premise that the mental health of the men in the Army depended upon morale, leadership, and personnel policies was new to them, and that psychiatric knowledge could be useful in these matters was not readily apparent. The thinking of Army authorities on the subject in the early part of the war was vividly, if somewhat informally, described by a member of the General Staff subsequently assigned to investigate the psychiatric problem in the Army.[24]

If the War Department General Staff was alarmed over the large number of men who were being discharged from the Army for psychiatric disorders, their confusion concerning this problem is perhaps shown even more clearly by the fact that in the spring and summer of 1943 they issued a series of directives which resulted in discharging even more men.[25]

These three directives pertained only to psychiatric cases, but about the same time, WD Circular No. 161 was issued (14 July 1943). This directive eliminated the category "limited service" in the Army and ordered the discharge of all men suffering from any type of disorder which prevented them from doing full combat duty.

However, psychiatrists in the Surgeon General's Office were not consulted by the authorities at this time. The directives were issued by the War Department General Staff, mainly the Assistant Chief of Staff for Personnel, G–1, over the psychiatrists' ineffective protests. In any event, as a result of these directives, more and more men began pouring out of the Army. It soon became evident that the situation was getting out of

[24] Cooke, Elliot D.: All But Thee and Me. Psychiatry at the Foxhole Level. Washington: Infantry Journal Press, 1946, p. 7.

[25] See footnote 2, p. 379.

hand and that drastic action was needed to prevent the Army from being decimated. Urgent telegrams were dispatched calling an abrupt halt to all discharges, and for a period, no man was discharged from the Army for any reason, pending the preparation and publication of new discharge criteria. War Department Circular No. 293, issued on 11 November 1943, completely reversed the discharge policy. Then, for the first time, psychiatrists were permitted to participate in formulating a policy of discharge for psychiatric reasons. This appeared as Circular Letter No. 194, Office of The Surgeon General, and was issued on 3 December 1943. The directive stated: "* * * a man will not be separated from the service merely because he has or has had a psychoneurosis or similar psychiatric disorder." Each case was to be evaluated individually and disposition made on the basis of clinical judgment as to the "individual's potential value to the service."

Although the War Department General Staff now accepted the fact that further screening was not the answer to the psychiatric problem, it still did not provide a solution. Instead, considerable correspondence was generated not only in Washington but also in the oversea theaters relative to this problem, and the Inspector General was ordered to investigate.[26]

SUMMARY

In the beginning of World War II, military authorities, both lay and medical, believed that psychiatric disorders occurred only in predisposed individuals—weaklings. This led to the endorsement of and the reliance upon the policy of psychiatric screening. As the war progressed, these authorities discovered that most mental disorders occurred in "normal" men and that screening was ineffective in preventing the occurrence of such conditions. Then, thinking ultimately changed. Instead of screening and elimination, the policy changed to conservation and utilization of manpower and to the acceptance of psychiatric knowledge for the purpose of prevention. The culmination of this policy change came with the publication of WD Circular No. 81, issued on 13 March 1945, which was one of the chief accomplishments of preventive psychiatry in World War II. This directive not only restricted the use of the generic term "psychoneurosis" as a diagnosis but also contained a very important section which is quoted as follows:

Utilization and prevention.—The majority of the factors which determine the mental health of military personnel are functions of command. In other words, the

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[26] (1) Memorandum, Assistant Deputy Chief of Staff, for the Assistant Chief of Staff, G–1, 28 Sept. 1944, subject: Psychoneurotics. (2) Memorandum, Assistant Chief of Staff for Personnel (G–1), for Chief of Staff (North African Mediterranean theater), subject: Psychoneurotics. (3) Memorandum, Assistant Chief of Staff, G–1, for Commanding General, ASF, 12 Oct. 1944, subject: Psychoneurotics. (4) Report, The Inspector General, to Assistant Chief of Staff, G–1, 17 Dec. 1944, subject: Psychoneurotics. (5) Memorandum, Assistant Chief of Staff, G–1, for Deputy Chief of Staff, 4 Feb. 1945, subject: Psychoneurotics.

main job of preventive psychiatry must be done by commanding officers of the line. It is a responsibility of command to obtain maximum utilization of manpower by providing proper incentive and motivation, and such reclassification, reassignment, rest, relaxation, and recreation as exigencies of the military service permit. The psychiatrist acts as adviser to the command. In training centers or in Army divisions as a member of the division surgeon's staff, he is to be regarded as having staff function in advising the command on policies and procedures which affect mental health and morale. In certain divisions and in some commands there appear to be excellent morale and splendid accomplishment which are in part due to an ideal relationship between the psychiatrist, the surgeon, and the responsible officers of the commander. It is the responsibility of the psychiatrist to be alert to the situational factors which are precipitating psychiatric disorders and to recommend the measures necessary to alleviate or remove these factors. He should survey the training program from a psychiatric viewpoint, advise concerning schedules, the method of conditioning troops to battle situations, and adjustment to extremes in climate. He should pay close attention to such matters as the furlough policy and the handling of AWOL cases. Through collaboration with the personnel classification officer he should be able to prevent many psychiatric disorders by bringing a medical viewpoint to bear in the job assignment problems. He should be alert to evidence that troops are approaching the limit of their endurance and in need of rest. Equally, he should be alert to untoward effect of boredom from excessive idleness. He should advise other agencies which are important to the morale and mental health of the troops: the Information and Education officer, the Chaplain, the Red Cross, and the Special Services Officer.

Additional measures were also studied and developed in the preventive psychiatry program. These included WD Circular No. 48 (3 Feb. 1944), TB MED's 12 (22 Feb. 1944) and 21 (15 Mar. 1944), the combat treatment plan, the tour of combat duty, the Infantryman's Badge, the point system of discharge from the Army, the "Why We Fight" films, and "Army Talks" system, and certain other measures. Through these various measures, an acute awareness was finally developed in the benefits to be derived from a planned preventive psychiatry program, and the important role that it could play.

CHAPTER XV

The Women's Army Corps

Margaret D. Craighill, M.D.

This is a historical survey of the psychiatric problems incident upon the service of women volunteers in nonprofessional occupations who were recruited for the Army in World War II, during a 3½-year period beginning in June 1942. Occasional reference is made here to the relationship of female volunteers to the male components of the Army. Emphasis in this chapter, however, is upon the administrative policies and professional medical problems of these female volunteers and upon the emotional impact of a new and unusual environment of war upon women military personnel.

DEVELOPMENT

The WAAC (Women's Army Auxiliary Corps) was established by act of Congress on 15 May 1942.[1] It was reorganized as the WAC (Women's Army Corps) and incorporated into the AUS (Army of the United States) on 1 July 1943. Some 147,000 women were brought into the Army as Waacs or Wacs: 77,000 under the WAAC program and 70,000 under the WAC program (table 30).

Policies of all kinds had to be made in relation to medical conditions peculiar to this group, both as women and as minority members of the much larger organization of men with whom they were closely associated.

TABLE 30.—*Accessions of personnel in the Women's Army Corps (WAAC and WAC), 1942–45*

Category	Total	Officers	Enlisted personnel
WAAC (May 1942 through July 1943)	76,638	5,578	71,060
WAC (August 1942 through December 1945)	70,442	1,489	68,953
Total	147,080	7,067	140,013

Source: Strength of the Army (STM–30), Department of the Army, 1 February 1948, as revised.

[1] Treadwell, Mattie E.: Special Studies: The Women's Army Corps. United States Army in World War II. Washington: U.S. Government Printing Office, 1954, p. 45.

Previously, all female components of the Army had been given officer status, solely because of specialized training, such as nursing, physiotherapy, and dietetics. The professional women in these components were a much more homogeneous group than those in the WAAC or WAC which were composed of heterogeneous elements who had merged together because of a community of interest in the service of the Army. The Waacs or Wacs suffered from, and yet also profited by, a great diversity in social and educational endowment. They represented, to some extent, a cross section of American womanhood coming from the farm and from the factory, from the office and from the home.[2]

The WAC and other women's components of the Army had three basic characteristics in common which differentiated their psychiatric problems from those of men. Two of these factors were inherent in the Army organization; namely, in that their members were volunteers and were noncombatants. The other was a more fundamental characteristic—they were women. Because the Wacs were all volunteers, there was a self-selection which made them less typical of American womanhood than were the men who were drafted by selective service. This difference, although not the only influence, was reflected in rejection rates, as shown in a 6-month period in 1944, when the ratio of neuropsychiatric rejections for men was twice that for Wacs.[3]

RELATIONSHIP TO MEDICAL SERVICES

Surgeon General's Office

Although The Surgeon General was technically responsible for the medical care of the WAAC, there was little consultation or supervision until shortly before the inclusion of this auxiliary group into the Army. This function of The Surgeon General was then delegated to the first woman medical officer in the Army of the United States, Maj. (later Lt. Col.) Margaret D. Craighill, MC (fig. 42), in her assignment as Consultant for Women's Health and Welfare to The Surgeon General. This involved liaison with the Director of the WAC, Col. Oveta C. Hobby (fig. 43). Medical policies in relation to Wacs were initiated in the office of the consultant and were processed through appropriate divisions in both the

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[2] Craighill, M. D.: Psychiatric Aspects of Women Serving in the Army: The Motivation of Women Volunteers. Am. J. Psychiat. 104: 226–230, October 1947.

[3] Another more valid explanation for the higher rejection rates for men as compared to those for Wacs was the deliberate policy of higher rejections for men (see chapter VIII, "Selection and Induction") as contrasted with the strong efforts made to enlist women, disregarding psychiatric standards for induction. Further, women candidates were screened before the medical examination on the basis of the data submitted by them on their applications and a special "mental alertness test." Also, as stated by the author, volunteer women were more prone, than were draftees, to conceal symptoms of emotional disorder and past history of mental disease. It should also be recognized that for some time the supply of men was considered to be inexhaustible and, therefore, any doubtful male inductee could be readily rejected. This policy was reversed with women volunteers in order to build up a desired strength of the WAC.—A. J. G.

FIGURE 42.—Lt. Col. Margaret D. Craighill, MC.

Surgeon General's Office and the WAC headquarters. In this connection, the consultant, although not a psychiatrist, worked closely with the staff of the Neuropsychiatry Consultants Division, SGO (Surgeon General's Office). Recognizing that neuropsychiatric conditions would be the major medical problem, the Surgeon General's Office brought this issue to the attention of the service command and WAC headquarters. Almost a year elapsed, however, before those authorities realized the extent and seriousness of the neuropsychiatric problem.

Medical Care

Medical care of Wacs, both in the Zone of Interior and overseas, was under the appropriate Army medical authority. Wherever there was a large contingent of Wacs, a medical officer was usually assigned especially for their needs, and a dispensary was established for sick call. Hospitalization was accomplished similarly as for other women in, or

FIGURE 43.—Lt. Col. Margaret D. Craighill, MC (left), and Col. Oveta Culp Hobby, Director, WAC (right).

connected with, the armed services. Medical services for the enlistment stations were usually supplied by local induction centers.

Before the commissioning of women as medical officers, there were several women physicians in the WAAC who were assigned to the training centers. Three of these, one a psychiatrist, went overseas with the first WAC contingents. As more women physicians received commissions in the Army Medical Corps, many were assigned to duty with WAC units in various parts of the world. The need for psychiatrists, especially at the WAC training centers, was recognized, and special attention was given to staffing these training centers with qualified medical officers.

PROCUREMENT

Motivation

Motivation for service were almost as divergent as the backgrounds of the women volunteers. There were some who volunteered for purely patriotic reasons and at considerable sacrifice of their own position and comfort. For many, however, this ideal was mixed in varying proportions with, or completely overshadowed by, more personal reasons. Some were influenced by a general masculine identification; others were substituting for a husband, brother, or father who was dead or disabled; and still others were competing with those significant male figures who were living. Women so impelled were usually fairly stable, and their motivation

was of sufficient strength to carry them through the vicissitudes of military experience.

Another group enlisted in the hope of meeting more men, or for the glamour and excitement. Many of these volunteers were immature women whose enthusiasm could not stand up to the hard reality of discipline and to the monotony of army life. Then, there were the escapists who were running away from either internal conflicts or external problems in their environment. These women included those who wanted relief from rigid, or otherwise intolerable, home situations; those who were seeking substitutes for disappointment in love or marriage; and those who had always been maladjusted and were seeking that "green field" which is never found. Many of the neurotics were in this escapist group, and most were unable to resolve their previous maladjustment. It was mainly the women in this group who were responsible for numerous company problems and who were given disability discharges. A minority of them, however, did find in the orderly and disciplined routine of army life the support and leadership which they had needed, and these women became happy and useful members of the organization.

Another motivation for a large number of volunteers was a desire for occupational change. This change benefited the relatively untrained women because they were given opportunities to learn new skills or become proficient in unfamiliar techniques. However, those who sought such a change of occupation merely because of boredom were frequently disappointed to find themselves doing the same cooking or stenographic work that they were trying to avoid. In some instances, the new work was more menial than the former civilian occupation and intensified frustration.

A study[4] of approximately 18,000 women at the training center at Fort Des Moines, Iowa, gave the following statistical information on motivation:

> * * * 35.03 percent * * * to satisfy their needs for masculine identification; 16 percent to fulfill a need for justification, guilt, or sacrifice; 16 percent * * * patriotic or service motive; 13 percent * * * escape the monotony of their civilian existence or unpleasant home situation; 8 percent * * * security or benefit themselves; 6 percent * * * hysterical and impulsive motives; and 4 percent * * * to be like other women, to justify the use of women in military service or through a maternal influence.
>
> It was found that neither emotional, practical, or intellectual motivation was a guarantee for success in the WAC. The healthier and more realistically motivated women were usually better adjusted and more efficient in their service. The greater the opportunity given for fulfillment of the motivation for enlistment the greater were the gains both personal and military.

Recruitment

As indicated before, the recruiting resulted in the enrollment of some 147,000 personnel for the WAAC and WAC.

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[4] Preston, Albert, Jr.: History of Psychiatry in the Women's Army Corps, 1946, p. 4. [Official record.]

Officers

The most outstanding results of recruitment were in the first group of officer candidates. From 30,000 applicants, 360 were initially chosen after a thorough screening process.[5] Subsequently, 1,300 more were selected from this group. In commenting on recruitment, Preston[6] stated:

> The results of this screening procedure were excellent, and with few exceptions the women selected during this period became the outstanding women of the WAC, not because they were the first chosen but because of their excellent qualifications and selection. Almost all of these women have justified the original opinion concerning their suitability.

No officers, except the Director, were commissioned directly from civilian life.

After the original group of officer candidates were indoctrinated and commissioned, all subsequent officers were chosen from enlisted personnel and given special training. Preston[7] described this selection as follows:

> The later officers were selected from the ranks. Every effort was made to assure selection of the best material available but this selection was at times "hit and miss." At one period when there was a great need for WAC officers anyone with an AGCT [Army General Classification Test] score of 110 was considered, regardless of ability and experience; occasionally a woman who had a personality problem in her field unit was sent to OCS [Officers' Candidate School] as a means of changing her assignment; others who had done a clerical job in an efficient manner were sent and those who were popular with their company commanders. Also women who would repeatedly ask to be sent were assigned to OCS without qualification, and women who did one specific assignment well but who had no other qualifications were sent with the idea that they could come back to their original assignment and perform the same duties as an officer. Thus it was recognized early in the history of the Corps that selection of the candidates to attend Officers' Candidate School was an important decision.

Several trial methods of improving selection were instituted until finally a plan was worked out which set up an advisory committee of WAC officers and a psychiatrist and psychologist, who assisted in the selection and continued observation of the candidates. The committee recommendations were "helpful in supplying substantial reasons for elimination at screening boards. It also served to assist the eliminated candidate to accept her failure and to aid the company officers in understanding the personality of the women she trained."

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[5] Rather than screening, this procedure was a selection process by which approximately 1 percent of the best qualified women volunteers were chosen. As stated by Treadwell, *op. cit.*, pages 57–58: "The final selection process was of unequaled intensity. * * * eleven prominent psychiatrists searched the work histories for evidences of mental instability * * *. Answers to the essay question on 'Why I Desire Service' were believed to be particularly revealing. * * * The Director [Colonel Hobby] personally read each of the final papers. * * * Of the selected [360] candidates * * * 99 percent had been successfully employed in civil life * * * 90 percent had college training. * * * The candidates included * * * a dean of women, a school owner and director, a personnel director, a Red Cross official, a former sales manager, and several editors, and there were many more who had been reporters, office executives, lawyers, social workers, Army employees, and teachers."—A. J. G.

[6] Preston, *op. cit.*, p. 8.

[7] *Ibid.*, p. 13.

Under these programs, 5,578 women were commissioned as WAAC officers and 1,489 as WAC officers, or a total of 7,067 officers (including warrant officers) (table 30).

Enlisted women

Recruitment of enlisted women for the WAAC and the WAC was done by quota in the various service commands. Quantity was stressed rather than quality. The requirement of raising a quota prompted inducements which often attracted undesirable persons and was responsible for later disillusionment and dissatisfaction because of false impressions received during recruiting campaigns. The maladjusted woman, lured by the glamour, enlisted as a means of escape. The anxiety to fill the quota, however, was so great that intense pressure for waivers was often exerted by recruiting officers. This was reflected in the variation of rejection rates in the different service commands, which will be noted in more detail later. It was apparent that such differences in rejection rates did not derive from the quality of the candidates but rather from the policy of commands in the procedure of examinations.

Psychiatric examinations were not encouraged in many areas until later experience demonstrated clearly the need for better recruiting procedures. Many recruiting devices were used, even to a guarantee of job or station assignment, according to the applicant's wishes. This was later abandoned because of findings that such practices were neither in the best interest of the service nor of the recruit.

Reenlistments.—In the change from the auxiliary to the AUS, 14,607 enrolled women and 343 officers did not reenlist. More than 75 percent chose to reenlist; that is, a total of 41,177.[8] A study made of the reasons for reenlistment indicated: "Waacs remained at stations where they were wanted and needed in their jobs." [9] They were influenced by association with good WAAC commanders and by the attitude of superior officers, including commanding generals. Those who did not reenlist were disgruntled by experience with faulty classification and assignment and by overstatements and unfulfilled promises of recruiting officers. Many were persuaded by family and friends to leave the service, because of the unfavorable publicity that had been given the WAAC.

Medical reasons also accounted for many of the failures to reenlist. Final-type physical examinations were required of all who had not been examined since 1 March 1943, a period of 6 months before the actual enlistment in the Army of the United States.[10] At least one-third were disqualified, because of the more exacting physical standards and the improved

[8] Treadwell, *op. cit.*, p. 228.

[9] *Ibid.*, p. 226.

[10] War Department Circular No. 146, 26 June 1943, sec. III, amended by War Department Circular No. 173, 27 July 1943, sec. II.

quality of entrance examinations. This is reflected in the increased number of CDD's (certificates of disability for discharge) during the 4 months' period before September 1943, in which the changeover occurred.[11]

ENLISTMENT PHYSICAL EXAMINATION PROCEDURES

General Considerations

Until after the change to WAC, recruiting centers did not emphasize the importance of physical standards, and few attempted psychiatric evaluations. With pressure from the Surgeon General's Office, which included personal inspection of many of the centers, analysis of the discharge rates for neuropsychiatric disorders, and followups in the service commands of enlistees who were medically discharged within 6 months, the quality of examinations improved. An attempt was made to reduce the number of examining stations to make available more adequate psychiatric consultation, but this plan was never successfully achieved. A special study of Waacs discharged for disability (all causes) by length of service indicated that somewhat over one-half of them (52 percent) were in the service less than 4 months and about three-fourths were in the service less than 5½ months (table 31). (The discharges for disability are further discussed in more detail in subsequent sections.)

TABLE 31.—*Distribution of Waacs discharged from the service, by length of service and selected causes of disability discharge, May 1943*

Length of service (months)	Percent distribution by selected cause of disability discharge			
	All causes	Neuropsychiatric	Gynecological	Other
1 to 2	2.4	3.3	1.7	1.7
2 to 3	23.6	15.0	33.6	27.0
3 to 4	26.0	27.2	24.2	26.1
4 to 5	18.3	21.1	14.7	17.4
5 to 6	11.4	13.4	9.5	10.4
6 to 7	5.6	7.8	6.0	1.7
7 to 8	6.8	8.3	6.0	5.2
8 to 9	3.4	3.3	.9	6.1
9 to 10	2.5	.6	3.4	4.4
Total	100.0	100.0	100.0	100.0

Source: WAC Enrollment Data, Distribution of Waacs Discharged From the Service Due to Disability, by Cause, August 1942 through May 1943. Report No. 3–W, Medical Statistics Division, Office of The Surgeon General, War Department, 17 Aug. 1943.

[11] Treadwell, *op. cit.*, appendix A, table 12.

Rejection Rates

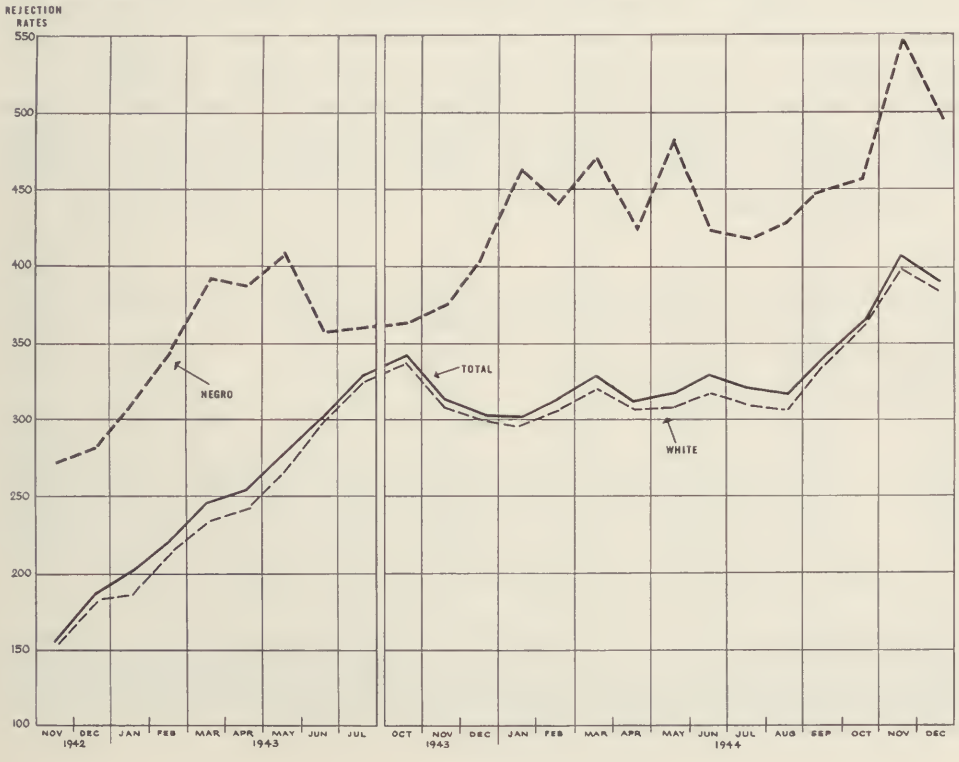
WAAC.—No complete data are available on the rejections of Waacs for military service, inasmuch as the first report providing such data was submitted to the Surgeon General's Office in November 1942. (It may be recalled that the WAAC program began in June 1942.) The available rejection data are summarized by race in table 32, and shown by month and by race in table 33.

Some 23 percent of the WAAC candidates failed to meet the medical requirements: 22 percent of the white WAAC candidates and 35 percent of the Negro WAAC candidates. The rejection rates for medical reasons among Negro candidates were thus some 56 percent higher than among the white WAAC candidates. (These data exclude rejections on the basis of personal interview, referred to as administrative separations; they also exclude candidates who were eliminated before the medical examination on the basis of their application and the "mental alertness test.")

The trend of the rejection rates for medical reasons is reflected in the

CHART 10.—*Rejection rates of WAAC and WAC candidates, by month and race, November 1942 through December 1944*

[Rate expressed as number of candidates rejected per 1,000 examined]



monthly data, shown by race, in table 33 and graphically illustrated in chart 10. The data indicate, in general, a steady increase in the rejection rates, from month to month.

For the total (white and Negro) Waacs, the rejection rate rose from 158.5 in November 1942 to a rate of 328.1, per 1,000 candidates examined in July 1943. The total rejection rate somewhat more than doubled during this period.

This sharp rise in the total rejection rate is due primarily to the increase in the rejection rates of the white WAAC candidates. Their rate increased from 152.3 in November 1942, to 329.4 in July 1943, per 1,000 white candidates examined—an increase of 116 percent.

The increase in the Negro WAAC rejection rates was not so sharp. It must be recognized, however, that the initial rejection rate was much higher (above 50 percent) than that of the white WAAC candidate. At their highest point (May 1943), the Negro rejection rate was 407.2, about 48 percent higher than it was in November 1942 (the rate was then 274.4). (Their lower rejection rates for June and July 1943 relate to rather small numbers of candidates examined and to that extent these rates may not be representative of the broader trend.)

Of the most noted factors associated with the upward trend of medical rejections among WAAC candidates is the fact that the rejection rates increased as the number of WAAC candidates decreased. The indications are that the larger numbers of WAAC candidates in the early months of 1943 represented more physically fit candidates than those examined in the later months. It is also possible that the more desirable candidates were enrolled in the WAAC during the earlier months. Furthermore, the subsequent recruiting campaigns for the WAVES (women accepted for volunteer emergency service), the SPARS (Coast Guard Women's Reserve), and the Marines might have drawn off some of the better material. Also, the

TABLE 32.—*Results of the medical examination of enlisted WAAC and WAC candidates, by race, November 1942 through December 1944* [1]

Personnel	Number examined			Number accepted			Rejection rates [2]		
	Total	White	Negro	Total	White	Negro	Total	White	Negro
WAAC	77,035	71,639	5,396	59,120	55,606	3,514	232.6	223.8	348.8
WAC	88,381	84,222	4,159	59,064	56,760	2,304	331.7	326.1	446.0
Total	165,416	155,861	9,555	118,184	112,366	5,818	285.5	279.1	391.1

[1] Based on Surgeon General's Monthly Reports of WAAC and WAC enlistments, SGO Form 467, received from WAAC and WAC recruiting stations. No reports were received before November 1942 and none after December 1944. The number of accepted enlisted candidates as reported here constitutes thus 84.4 percent of the total number (140,000) of WAAC and WAC enlisted from July 1942 through December 1945, as reported in the Strength of the Army (STM–30) under WAAC and WAC accessions. (See table 30.)

[2] Rate expressed as number rejected per 1,000 examined.

TABLE 33.—*Results of the medical examination of enlisted WAAC and WAC candidates, by month and race, November 1942 through December 1944* [1]

Month and year	Number examined			Rejection rates [2]		
	Total	White	Negro	Total	White	Negro
	WAAC					
1942						
November	5,275	5,009	266	158.5	152.3	274.4
December	8,056	7,572	484	186.9	180.9	281.0
1943						
January	12,558	11,595	963	201.5	192.5	310.5
February	15,854	14,670	1,184	224.6	214.5	349.7
March	14,638	13,453	1,185	247.0	234.2	391.6
April	7,174	6,637	537	255.5	244.8	387.3
May	5,234	4,846	388	276.3	265.8	407.2
June	4,534	4,305	229	301.9	299.0	358.1
July	3,712	3,552	160	328.1	329.4	300.0
Total	77,035	71,639	5,396	232.6	223.8	348.8
	WAC					
1943						
October	4,944	4,709	235	340.8	339.8	361.7
November	4,866	4,673	193	313.4	310.9	373.1
December	4,658	4,480	178	304.4	300.4	404.5
1944						
January	5,552	5,357	195	301.3	295.5	461.5
February	5,819	5,574	245	313.6	308.0	440.8
March	6,794	6,492	302	327.1	320.4	470.2
April	6,083	5,793	290	311.7	306.1	424.1
May	7,159	6,808	351	315.8	307.1	484.3
June	7,597	7,231	366	328.3	323.6	420.8
July	6,431	6,098	333	320.0	314.7	417.4
August	6,745	6,427	318	315.2	309.6	427.7
September	6,032	5,758	274	342.5	337.4	448.9
October	6,440	6,110	330	366.9	362.0	457.6
November	5,099	4,784	315	407.7	398.4	549.2
December	4,162	3,928	234	390.7	384.2	500.0
Total	88,381	84,222	4,159	331.7	326.1	446.0

[1] See footnote 1 to table 32.

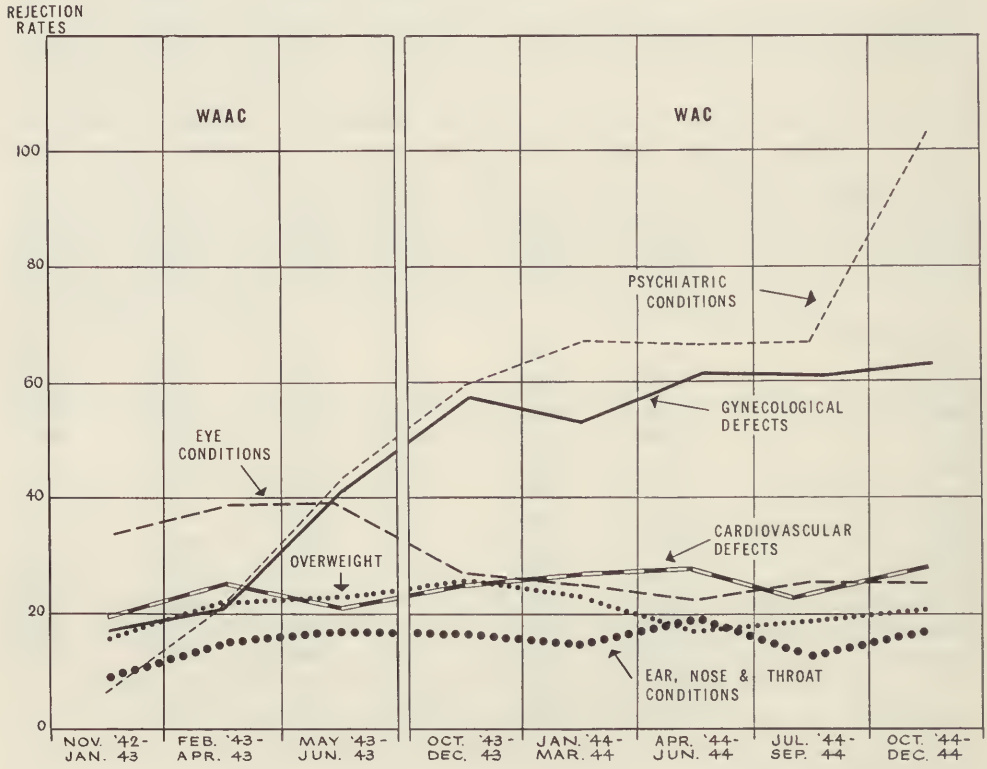
[2] Rate expressed as number rejected per 1,000 examined.

increasingly more searching medical examinations and the greater experience of the examiners could have been important factors in increasing the medical rejection rates in the later months.[12]

The leading diagnostic causes of rejection that were principally responsible for the sharp increase in the rejection rates for medical reasons were the psychiatric and gynecological disorders. For psychiatric conditions, the rejection rate increased from 6.1 per 1,000 examined in the early 3-month period (November 1942 through January 1943), to a rate of 43.5 in the last 3-month period (from May 1943 through July 1943). The rejection rates for gynecological reasons rose during the same periods from a rate of 16.7 to a rate of 41.0 per 1,000 Waacs examined. The other leading selected diagnostic causes of rejections indicate some upward, but evidently by far a less pronounced, trend (table 34, chart 11).

There were noted during this period wide variations in the rejection rates by service command. Even in the last 4 months of this period (from

CHART 11.—*Leading causes of rejection among WAAC and WAC candidates for medical reasons, November 1942 through December 1944, by quarters*



[12] WAAC Enrollment Data, Results of Medical Examinations of WAAC Candidates, April–July 1943, Report No. 4–W, Medical Statistics Division, Surgeon General's Office, War Department, 21 Oct. 1943.

April 1943 through July 1943), when the total rejection rate indicated some signs of leveling off, the differences by service command were still very marked. The total rejection rates ranged from 186.7 in the Fourth Service Command to 342.4 in the Second Service Command, per 1,000 WAAC candidates examined (table 35).

TABLE 34.—*Medical rejection rates of WAAC and WAC candidates, by diagnosis, November 1942 through December 1944*

Disease and disorder	WAAC				WAC					
	1942–43	1943		Total	1943	1944				Total
	November–January	February–April	May–July		October–December	January–March	April–June	July–September	October–December	
Neurological	5.3	8.4	13.4	8.2	10.1	5.1	3.5	8.5	8.5	6.9
Psychiatric	6.1	20.9	43.5	19.9	59.5	67.8	66.4	67.6	103.7	72.4
Gynecological (including urinary)	16.7	20.9	41.0	23.1	57.5	53.7	61.1	60.3	65.9	59.6
Cardiovascular (excluding hypertension)	18.5	24.7	20.6	21.9	25.3	26.3	27.6	22.7	27.1	25.8
Musculoskeletal (excluding hernia and flatfoot)	4.8	7.8	8.1	6.8	8.9	6.9	7.9	9.1	13.3	9.1
Pulmonary tuberculosis	11.9	11.7	14.6	12.3	13.4	12.4	12.6	11.8	10.3	12.1
Respiratory (excluding tuberculosis)	3.8	4.1	6.2	4.4	4.0	6.9	4.9	7.4	8.0	6.3
Eye conditions	33.9	38.4	39.6	37.1	27.1	24.8	22.5	25.6	25.9	25.0
Ear, nose, and throat	9.1	14.8	16.5	13.2	16.1	14.9	19.2	13.8	17.3	16.3
Oral	7.8	6.6	3.0	6.4	11.4	13.1	7.6	8.0	7.8	9.5
Syphilis	13.0	13.5	8.2	12.4	11.4	10.6	12.9	10.7	13.8	11.9
Gonorrhea	1.4	2.5	1.9	2.0	1.2	1.5	3.2	2.2	5.1	2.7
Other venereal diseases	1.0	.7	1.0	.8	.3	.8	.7	.4	.6	.6
Gastrointestinal	2.2	2.4	3.9	2.6	2.0	2.1	2.7	4.5	3.1	2.9
Flatfoot	2.1	3.5	4.5	3.2	4.6	4.6	4.3	4.5	4.6	4.5
Overweight	16.3	21.4	22.0	19.8	25.7	23.4	17.9	18.9	21.8	21.2
Underweight	11.4	9.9	18.0	11.8	13.3	14.2	15.9	16.6	17.3	15.5
Underheight	6.7	7.2	6.8	7.0	2.5	2.4	3.1	2.7	2.3	2.6
Miscellaneous	16.1	19.8	26.4	19.7	25.6	23.4	25.0	30.1	30.1	26.8
Total	188.2	239.2	299.2	232.6	319.9	314.9	319.2	325.4	386.5	331.7
Number examined	25,889	37,666	13,480	77,035	14,468	18,165	20,839	19,208	15,701	88,381

Source: Karpinos, Bernard D., and Wann, Marie E.: Certain Characteristics and Medical Findings on WAAC and WAC Candidates. [Unpublished manuscript.]

TABLE 35.—*Medical rejection rates of Waacs, by service command and diagnosis, April through July 1943*

[Rate expressed as number rejected per 1,000 examined]

Disease or disorder	Service Command								
	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth
Psychiatric	89.0	31.1	7.4	3.3	11.6	69.3	23.2	50.0	63.3
Eye condition	29.5	84.7	29.1	33.8	17.8	31.5	46.4	26.6	50.8
Ear, nose, and throat	25.9	15.4	11.1	10.9	12.0	26.5	16.9	8.7	21.1
Teeth	1.2	1.3	4.9	3.3	5.3	1.9	1.3	5.1	.7
Gynecological	34.2	19.2	9.9	25.1	52.4	42.4	26.3	52.1	16.8
Urinary (nonvenereal)	3.5	1.9	3.7	10.9	13.3	1.6	3.8	5.1	1.8
Syphilis	2.3	.6	3.7	9.8	6.6	1.2	3.8	18.3	1.1
Gonorrhea	1.8	.4	.4	3.3	3.6	1.2	.6	3.1	1.1
Other venereal	[1] .0	.6	[1] .0	[1] .0	5.8	[1] .0	[1] .0	.5	.7
Feet	.6	6.4	5.7	3.3	2.7	5.0	5.6	3.1	4.3
Musculoskeletal	2.9	5.1	2.9	5.4	5.8	11.7	9.4	11.2	10.7
Cardiovascular	25.9	13.1	15.6	19.7	24.4	20.2	16.3	25.0	33.2
Gastrointestinal	1.8	1.6	3.7	1.1	4.0	1.6	2.5	5.6	5.7
Respiratory (except tuberculosis)	2.9	6.1	4.1	8.7	10.2	1.2	5.0	4.1	7.9
Pulmonary tuberculosis	8.9	14.1	22.6	5.4	14.2	20.6	8.1	10.2	11.4
Neurological	6.5	12.2	3.3	2.2	28.8	4.7	22.6	21.4	14.7
Underheight	2.9	19.6	8.2	6.6	2.2	3.9	5.0	5.1	3.9
Underweight	6.5	37.5	18.9	18.6	11.1	9.0	11.9	12.8	6.4
Overweight	5.9	51.3	21.8	6.6	7.5	14.8	21.3	17.9	9.0
Miscellaneous	8.3	20.2	19.7	8.7	38.6	15.6	24.4	26.0	35.0
Total	260.5	342.4	196.7	186.7	277.9	283.9	254.4	311.9	299.6
Number examined	1,697	3,119	2,435	916	2,253	2,568	1,596	1,959	2,797

[1] Less than 0.1 of 1 percent.

Source: WAAC Enrollment Data, Results of Medical Examinations of WAAC Candidates, April–July 1943 Report No. 4–W, Medical Statistics Division, Office of The Surgeon General, War Department, 21 Oct. 1943.

The variations in the rejection rates by service command were even more extreme for specific medical causes than for all medical causes combined. The rejection rate for psychiatric conditions ranged, during this period, from 3.3 in the Fourth Service Command to 89.0 in the First Service Command, per 1,000 Waacs examined. Next in magnitude were the variations for gynecological disorders which ranged from 9.9 per 1,000 candidates examined in the Third Service Command to a rejection rate of 52.4 in the Fifth Service Command. Large differences were also found in the rejection rates for eye conditions; ear, nose, and throat conditions; foot defects; and certain other causes of rejection (table 35).

While certain allowances may be made for these variations by service command to actual geographic difference in the prevalence of these defects,

it seemed most likely that they were due primarily to lack of uniformity in the interpretation of the medical standards as well as to a certain laxity in the examinations per se. This has led to increased emphasis on the need for more adequate examinations, especially in regard to the psychiatric.

WAC.—Coincident with the conversion of the WAAC to WAC, which took place over a period of time extending from June through September 1943, both the age limits and the medical standards of examination were changed. Formerly, under the WAAC regulations, applicants for enrollment had to be at least 21 and not over 44 years of age; under the WAC standards, the age limits were extended from 20 through 49; and WAAC officer candidates were considered if over 44, but under 50 years of age. At the same time, the medical standards were modified for the Wacs to conform with those prescribed for Army nurses, except for the somewhat more lenient WAC standards for vision, height, and weight, which were retained. Pelvic examinations were made mandatory for all WAC candidates, and the various disqualifying conditions peculiar to women were specifically enumerated. It was further recommended that the pelvic examinations be made by a qualified gynecologist. The instructions pertaining to other phases of the examination were also amplified to require a psychiatric and neurological examination by a neuropsychiatrist. These changes were to make the psychiatric and physical requirements for enlistment in the WAC somewhat more stringent than those for the WAAC.[13]

The rejection rates of WAC candidates are shown by month, as those of the WAAC, in table 33 and graphically depiced in chart 10. The WAC data cover the period from October 1943 through December 1944. (No data are given for the period of conversion from WAAC to WAC.) The rates relate to medical reasons only. As in the case of the WAAC, these data exclude those WAC candidates who were eliminated before coming up for the medical examination on the basis of information submitted in their application and in most cases through the "mental alertness test."

In considering the total periods, namely, WAAC versus WAC, the rejection rates were much higher for the WAC: 331.7 Wacs rejected for medical reasons, as compared with 232.6 rejected Waacs, per 1,000 examined candidates, indicating an increase of 43 percent in the rejection rates. By race, the increase in the WAC rejection rates over those of the WAAC were 46 and 28 percent of white and Negro WAC candidates, respectively. (Although the rejection rates of Negro WAAC candidates were 56 percent higher than those of white WAAC candidates, those of Negro WAC candidates were 37 percent higher than the rejection rate of white WAC candidates.) (See table 32.)

With regard to psychiatric conditions, the rejection rate for the entire period, from October 1943 through December 1944, was 72.4 per 1,000 medically examined WAC candidates (table 34). As may be seen from these

[13] WAC Enlistment Data, Results of Medical Examinations of White WAC Candidates, Report 5–W, Medical Statistics Division, Surgeon General's Office, Army Service Forces, 6 Mar. 1944.

data, it rose from a rate of 59.5 in the last quarter of 1943 (October through December 1943); it remained about constant for 9 months (from January 1944 through September 1944), fluctuating around a rate of 67.0, but rose sharply in the last quarter of 1944 (a rate of 103.7) (table 34 and chart 11).

A similar trend of initial increase in the rejection rate, with a tendency to become stabilized, may be noted also in the rejection rates for gynecological disorders. Other defects, such as cardiovascular and ear, nose, and

CHART 12.—*Medical rejection rates of WAAC and WAC candidates, by diagnosis*

[Rate expressed as number rejected per 1,000 examined]

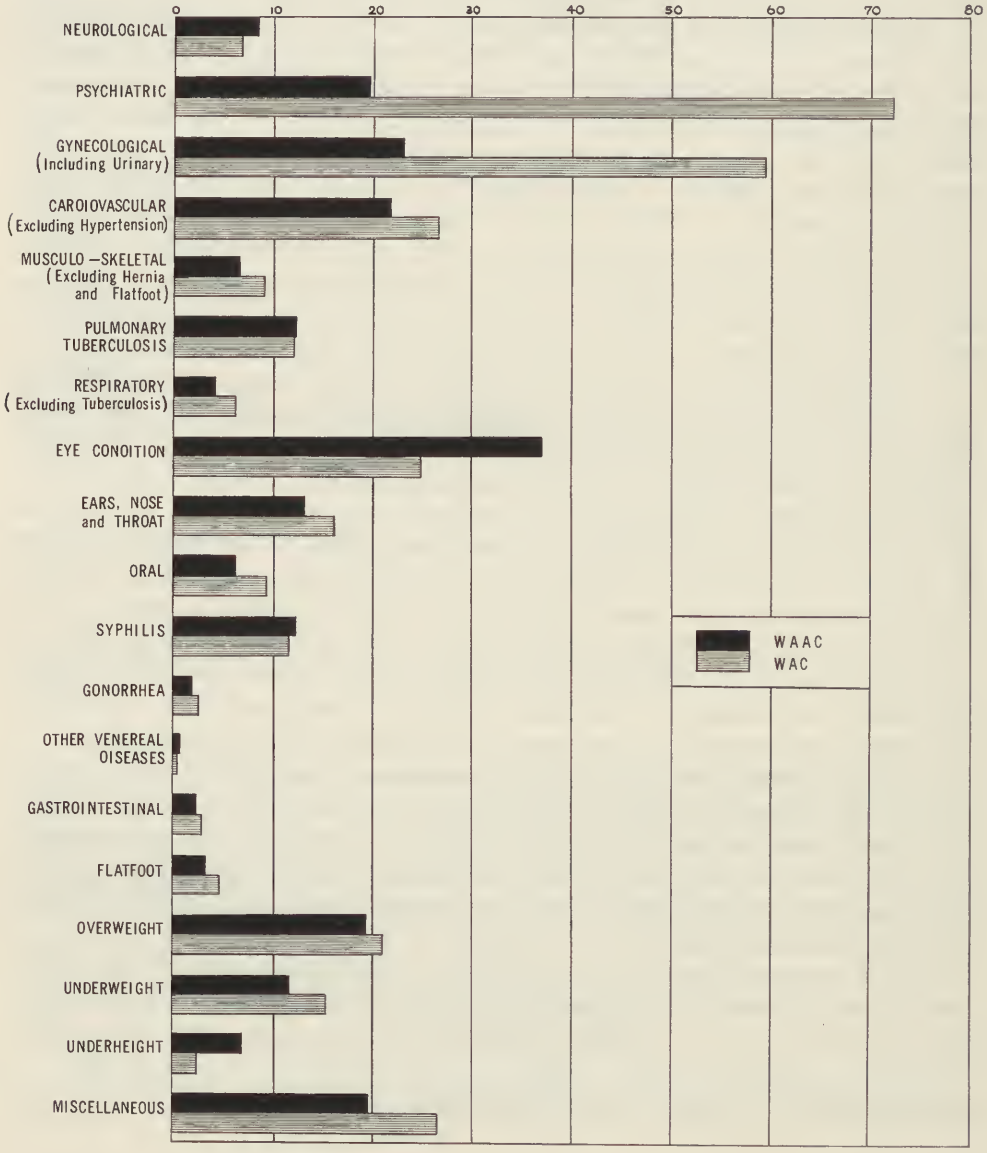


TABLE 36.—*Rejections of white WAC candidates, by specific diagnosis, October 1943 through March 1944*

Diagnosis	Rate [1]	Percent	Diagnosis	Rate [1]	Percent
Neurological	7.5	2.4	Respiratory (excluding tuberculosis)	5.7	1.8
Psychiatric	64.7	20.7	Eyes	25.9	8.3
Psychosis	2.7	.9	Myopia	8.0	2.6
Psychoneurosis	24.1	7.7	Amblyopia	8.4	2.7
Psychopathic personality	33.1	10.6	Other	9.5	3.0
Other psychiatric	4.8	1.5	Ear, nose, and throat	15.7	5.0
Gynecological (including urinary)	54.3	17.4	Otitis media	5.6	1.8
Lesions of cervix	11.9	3.8	Tympanic	4.2	1.3
Benign tumors of uterus	7.5	2.4	Nose, sinus, and throat	3.6	1.2
Relaxed vaginal outlet	4.9	1.6	Other ear defects	2.3	.7
Menstrual disorders	3.8	1.2	Oral	11.8	3.8
Other gynecological	12.7	4.1	Insufficient teeth	9.3	3.0
Urinary	13.5	4.3	Other oral defects	2.5	.8
Cardiovascular	34.4	11.0	Venereal diseases	9.2	2.9
Veins	6.1	2.0	Syphilis	7.5	2.4
Hypertension	8.9	2.8	Gonorrhea and other venereal diseases	1.7	.5
Other	19.4	6.2	Gastrointestinal	2.2	.7
Musculoskeletal (including hernia and flatfoot)	13.4	4.3	Build	40.4	12.9
Ankylosis	1.5	.5	Overweight	23.9	7.6
Arthritis	1.1	.4	Underweight	14.0	4.5
Deformities	4.4	1.4	Other build defects	2.5	.8
Flatfoot	4.4	1.4	Miscellaneous	14.7	4.7
Hernia	.7	.2			
Other musculoskeletal defects	1.3	.4	Total	312.6	100.0
Pulmonary tuberculosis	12.7	4.1			
Reinfectious type	7.9	2.5			
Primary	3.7	1.2			
Other	1.1	.4			

[1] Number rejected per 1,000 Wacs medically examined.

Source: Karpinos and Wann, *op. cit.* (table 34).

throat, show about constant rejection rates, while the rejection rates for eye conditions indicate a definite decrease (table 34, chart 11). (See also chart 12 for graphic presentation of the WAC rejection rates by diagnosis, compared with those of the WAAC.)

Of additional and important interest are the more specific diagnoses that are presented in table 34. Rejections of white WAC candidates for these medical reasons, during the 6-month period from October 1943 through March 1944, are presented in table 36.

The rejection rate of white WAC candidates for psychiatric reasons was 64.7 and for neurological reasons 7.5, or a rate of 72.2 for neuropsychiatric reasons per 1,000 white Wacs examined.

The rejection for psychiatric conditions constituted 20.7 percent of all rejections for medical reasons, among which psychopathic personality (10.6 percent) and psychoneurosis (7.7 percent) were the primary causes of the psychiatric rejections. About 23 percent of the Wacs rejected for medical reasons were rejected for neuropsychiatric disorders (20.7 for psychiatric and 2.4 for neurological disorders, table 36).

For the same period, about two out of every five men rejected at induction stations were excluded for such causes. One important reason for this difference arose from the fact that WAC candidates were volunteers, and self-selection operated to some extent to eliminate misfits. Of course, this favorable tendency was offset to some degree by the desire of these candidates to seek WAC service as an escape from, or a solution to, present personal difficulties which might have originally developed as a result of emotional instability. However, the first factor, that of self-selection, probably had the greater effect upon the rejection rate in reducing it below the level for men, who had no such choice regarding military service.

But, even with adequate psychiatric examination, the proper selection of female candidates was a more difficult procedure than it was with men. Women volunteers tried to conceal disabilities, whereas the reverse was often true with male inductees. Also, there was less past experience on which to base criteria for selection of those women who had a potential emotional capacity to adapt to regimentation.

It soon became apparent that, among the many factors that affected the psychiatric suitability of the Wacs, age was most important. Neuropsychiatric rejections for WAC candidates rose steadily with advanced age. Of the WAC candidates under 25 years of age, 56 per 1,000 were rejected for psychiatric reasons. This rate of rejection increased with age until, for the older age group, over 40 years of age, 88 per 1,000 examined candidates were so rejected (table 37).

Marital status made certain differences in the rejection for psychiatric

TABLE 37.—*Rejection rates of white WAC candidates, for neuropsychiatric conditions, by age, October 1943 through March 1944*

[Rate expressed as number rejected per 1,000 examined]

Age	Neurological	Psychiatric	Total neuropsychiatric
Under 25	6.3	55.7	62.0
25 to 29	7.4	60.5	67.9
30 to 34	8.8	68.3	77.1
35 to 39	8.3	78.9	87.2
Over 40	10.4	87.6	98.0
Total	7.5	64.7	72.2

Source: Karpinos and Wann, *op. cit.* (table 34).

TABLE 38.—*Rejection rates of white WAC candidates, for psychiatric conditions, by marital status and broad age intervals, October 1943 through March 1944*

[Rate expressed as number rejected for psychiatric conditions per 1,000 examined]

Age	Single	Married	Other [1]	Total
Under 25	53.9	55.0	74.5	55.7
Over 25	73.5	70.7	77.6	73.9
Total	60.7	64.5	77.0	64.7

[1] Refers to widowed, divorced, or separated.

Source: Karpinos and Wann, *op. cit.*, (table 34).

TABLE 39.—*Medical rejection rates of Wacs, by service command and diagnosis, October through December 1943*

[Rate expressed as number rejected per 1,000 examined]

Disease or disorder	Service Command								
	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth
Psychiatric	96.9	56.6	7.0	43.8	56.9	123.4	32.7	82.6	43.0
Syphilis	4.2	10.8	8.1	11.6	11.6	2.0	5.7	20.1	3.3
Eye conditions	16.0	67.3	30.6	16.5	18.7	25.5	19.9	18.0	19.8
Gynecological	27.8	43.6	36.5	36.4	97.0	17.8	70.4	46.5	44.1
Pulmonary tuberculosis	11.0	10.8	16.6	3.3	14.2	15.8	6.4	14.6	19.2
Cardiovascular	21.1	15.6	23.6	29.8	31.1	20.9	17.1	30.5	38.0
Overweight	13.5	51.7	22.0	11.6	28.5	22.9	43.4	9.0	17.6
Underweight	1.7	31.2	10.7	17.4	16.0	7.6	14.2	11.1	9.9
Ear, nose, and throat	11.8	17.2	24.2	8.3	13.3	19.9	19.9	15.3	13.8
Teeth	1.7	19.4	30.1	2.5	28.5	2.5	5.7	1.4	3.3
Neurological	[1] .0	3.8	9.1	5.8	11.6	2.0	22.8	22.9	16.5
Musculoskeletal	1.7	4.3	4.3	5.8	7.1	18.4	10.7	11.1	14.3
Feet	.8	11.9	3.2	5.8	.9	2.5	6.4	3.5	2.8
Genitourinary	7.6	3.2	8.1	10.7	22.2	29.1	10.0	20.8	6.1
Gonorrhea	[1] .0	.5	[1] .0	2.5	.9	[1] .0	1.4	3.5	1.7
Other venereal diseases	[1] .0	[1] .0	[1] .0	.8	[1] .0	[1] .0	.7	.7	.6
Respiratory (except tuberculosis)	1.7	2.2	2.7	10.7	8.9	1.5	2.8	2.8	6.1
Gastrointestinal	1.7	.5	3.8	.8	1.8	1.5	2.8	.7	4.4
Underheight	[1] .0	7.0	3.2	1.7	1.8	2.0	4.3	2.1	[1] .0
Miscellaneous	22.7	19.4	32.7	20.7	16.0	18.9	30.6	25.7	40.2
Total	241.9	377.0	276.5	246.5	387.0	334.2	327.9	342.9	304.7
Number examined	1,187	1,856	1,863	1,210	1,124	1,961	1,406	1,441	1,814

[1] Less than 0.1 of 1 percent.

Source: WAC Enlistment Data, Results of Medical Examinations of White WAC Candidates, Report No. 5–W Medical Statistics Division, Office of The Surgeon General, Army Service Forces, 6 Mar. 1944.

conditions. Compared with married women, the rejection rates for psychiatric conditions were somewhat higher for single women over 25 years of age. The total rejection rate for psychiatric reasons of single women, however, was found to be 60.7 per 1,000 candidates, lower than the rejection rates for married women, which was 64.5. The lower rate for single women is explained by the fact that the single women were relatively younger.

Definite differences were revealed for those classified as "other"; namely, the widowed, divorced, or separated. The data indicated higher rejection rates for these women by age, as well as for the total. Their total rejection rate for psychiatric reasons was 77.0—clearly much above those for single or married women (table 38).

Despite all the efforts made to bring about uniformity in the processing procedures of the WAC, differences in the rejection rates by service command persisted, as evidenced by the data in table 39. Of course, these rates relate to the earlier period of the WAC program.

Relation to discharge rates.—During the 10-month period of the WAAC, from August 1942 through May 1943, some 1,200 Waacs were discharged for disability.[14] Neuropsychiatric disorders accounted for 44.3

TABLE 40.—*Percent distribution of Waacs discharged from the service, by diagnosis, August 1942 through May 1943*

Disease or disorder	Percent distribution	Disease or disorder	Percent distribution
Neuropsychiatric diseases	44.3	Gastrointestinal	4.3
Psychoneurosis	38.2	Gastric and duodenal ulcers	1.0
Schizophrenia	2.0	Hernia	.7
Epilepsy	2.0	Other	2.6
Other	2.1	Eye, ear, nose, and throat	1.5
Gynecological	28.2	Eyes	.3
Infections and general disease	7.8	Ears	.7
Arthritis	3.8	Nose and throat	.5
Endocrine system	1.4	Respiratory (except tuberculosis)	1.4
Other	2.6	Venereal disease	.2
Musculoskeletal defects or disease	7.6	Syphilis	.1
Musculoskeletal disease	3.9	Gonorrhea	.1
Feet	3.6	Tuberculosis	.2
Other	.1		
Cardiovascular	4.5	Total	100.0
Organic heart disease	2.1		
Varicose veins	1.7		
Other	.7		

Source: WAAC Enrollment Data, Distribution of Waacs Discharged From the Service Due to Disability, by Cause, August 1942 through May 1943. Report No. 3–W, Medical Statistics Division, Office of The Surgeon General, War Department, 17 Aug. 1943.

[14] Derived from Treadwell, *op. cit.*, appendix A, tables 9 and 12.

TABLE 41.—*Percent distribution of white WAC separations, by length of service and age, October 1943 through October 1944*

Length of service	Under 25	25 and over	Total
Less than 3 months	24.0	23.0	23.4
3 to 6 months	34.8	31.5	32.7
6 to 9 months	28.9	29.3	29.2
9 months and over	12.3	16.2	14.7
Total	100.0	100.0	100.0

Source: Karpinos and Wann, *op. cit.* (table 34).

percent of the WAAC discharges for disability, among which psychoneurosis was the main diagnostic cause (38.2 percent of all disability discharges) (table 40). The discharges for disability for neuropsychiatric disorders were most likely to occur between the third and fifth months after enrollment (table 31). As reported by the Control Division, ASF (Army Service Forces), 28 May 1943—

> Most of the physical disabilities resulting in discharge of WAAC auxiliaries existed prior to enrollment, * * * indicating that thorough physical examination is not being given in many cases. Proper screening of enrollees would also result in rejection of many of the neurotics now being admitted only to be discharged later.

Of the Wacs separated for disability, about one-fourth (23.4 percent) had less than 3 months' service. Somewhat more than one-half of them (56.1 percent) were discharged within 6 months of their enlistment; 85.3

TABLE 42.—*Percent distribution of white WAC separations, by cause and length of service, October 1943 through October 1944*

Cause of separation	Percent distribution and length of service		
	Less than 6 months	6 months and over	Total
Neuropsychiatric	54.3	59.2	56.5
Genitourinary	19.7	19.0	19.4
Infections and general diseases	4.6	4.6	4.6
Musculoskeletal	6.7	2.9	5.1
Cardiovascular	4.6	3.8	4.2
Eye, ear, nose, throat, and respiratory diseases (excluding tuberculosis)	4.0	4.6	4.2
Gastrointestinal	1.9	1.9	1.9
Other	4.2	4.0	4.1
Total	100.0	100.0	100.0

Source: Karpinos and Wann, *op. cit.* (table 34).

percent of the discharged had less than 9 months of service (table 41, last column).

Above one-half (56.5 percent) of the WAC separations for disability were for neuropsychiatric disorders (table 42, last column). Again, as in the case of the WAAC, the WAC discharges for neuropsychiatric disorders were mainly for psychoneurosis: 44.3 percent of all disability discharges. In other words, somewhat above three-fourths (78.4 percent) of the neuropsychiatric discharges were for psychoneurosis (table 43).

The rates of the WAC disability discharges for all causes indicated an increase with age, marked especially in the "40 and over" age group (table 44). The same age pattern could be observed with respect to separations for neuropsychiatric disorders.

The disability discharge rates were much higher among married and "other" (widowed, divorced, or separated), than among single women (table 45).

When viewed from the point of view of the total WAAC and WAC experience, the separation data indicate that 8.3 percent of the enlisted Waacs and Wacs were separated for disability, prior to demobilization (table 46).

The disability discharge rates, relating to the mean annual strength, are presented by year in table 47. The high disability discharge in 1943 is to be attributed to the conversion procedures, from WAAC to WAC, which

TABLE 43.—*Percent distribution of white WAC separations, by diagnosis, October 1943 through October 1944*

Cause of separation	Percent distribution	Cause of separation	Percent distribution
Neuropsychiatric	56.5	Cardiovascular	4.2
Psychoneurosis	44.3	Organic heart disease (including valvular)	1.4
Psychosis	[1] 7.1	Varicose veins	1.2
Other	5.1	Other	1.6
Genitourinary	19.4	Eye, ear, nose, throat, respiratory (excluding tuberculosis)	4.2
Gynecological (excluding menopause)	10.3	Respiratory (excluding tuberculosis)	2.4
Menopause	7.8	Other	1.8
Other	1.3	Gastrointestinal	1.9
Infections and general disease	4.6	Result of traumatism	.7
Arthritis	3.5	Other	1.8
Other	1.1		
Musculoskeletal	5.1		
Feet	2.1		
Other	3.0	Total	100.0

[1] Includes 4.2 percent for schizophrenia.

Source: Karpinos and Wann, *op. cit.* (table 34).

TABLE 44.—*Separations for disability of white Wacs, by age and length of service, October 1943 through October 1944* [1]

[Rate expressed as number separated per 1,000 accepted]

Age	Less than 6 months	Total
Under 25	15.9	27.1
25 to 29	20.1	37.8
30 to 34	22.2	40.3
35 to 39	27.0	53.5
40 and over	52.3	92.2
Total	22.2	39.5

[1] These data relate to Wacs who enlisted during the period from October 1943 through March 1944 and were separated on certificates of disability for discharge during the period from October 1943 through October 1944.

Source: Karpinos and Wann, *op. cit.* (table 34).

TABLE 45.—*Separations for disability of white Wacs, by marital status and length of service, October 1943 through October 1944* [1]

[Rate expressed as number separated per 1,000 accepted]

Marital status	Less than 6 months	Total
Single	14.4	24.7
Married	36.7	64.8
Other [1]	31.9	60.7
Total	22.2	39.5

[1] See footnote 1 to tables 38 and 44. "Marital Status" at the time of enlistment.

Source: Karpinos and Wann, *op. cit.* (table 34).

required a final type of physical examination for all Waacs who had not been examined within 6 months prior to their enlistment.

Psychiatric Screening

The need for more adequate psychiatric screening of Wacs was given impetus in October 1943 by recommendations from the National Committee for Mental Hygiene which met at the Surgeon General's Office. This committee recommended that a social history record of the candidate be made available to the psychiatrist at the examining station.[15] This recommendation was implemented by the Neuropsychiatry Consultants Division, SGO,

[15] Memorandum, Col. Oveta Culp Hobby, WAC, for Assistant Secretary of War (thru: Commanding General, Army Service Forces), 8 Dec. 1943, subject: Plan for Psychiatric Screening of Applicants for Enlistment in the Women's Army Corps.

TABLE 46.—*Enlisted women (Waacs and Wacs) separated from the service, by cause of separation, August 1942 through December 1946*

Cause of separation	Number	Percent
Medical reasons	22,324	16.3
Disability discharges	(11,387)	(8.3)
Pregnancy	(10,937)	(8.0)
Inaptitude or unsuitability	1,322	1.0
Commissioned as officers	7,872	5.7
Honorable discharges [1]	61,155	44.6
Discharges other than honorable [2]	1,212	.9
Dishonorable discharges	71	[3].0
Deaths (nonbattle)	160	.1
Demobilization	43,093	31.4
Total	137,209	100.0

[1] Includes separations for overage, minority, dependency, importance to national health, safety, or interest, and so forth. Also included in this category are 14,199 enlisted Waacs separated at their request at the time of conversion to the WAC.

[2] Includes undesirable habits or traits of character and misconduct.

[3] Less than 0.1 of 1 percent.

NOTE.—Figures in parentheses are subtotals.

Source: Derived from: Treadwell, Mattie E.: Special Studies: The Women's Army Corps. United States Army in World War II. Washington: U.S. Government Printing Office, 1954, appendix A, tables 9 and 12.

TABLE 47.—*Discharges for disability and pregnancy of Waacs and Wacs, by year, 1942–46*

[Rate expressed as number of discharges per 1,000 mean strength per year]

Year	Discharges for—			
	Disability		Pregnancy	
	Number	Rate	Number	Rate
1942	47	18.6	16	6.4
1943	3,497	81.3	766	17.8
1944	3,094	44.1	3,612	51.5
1945	4,322	53.5	5,691	70.5
1946	427	22.5	852	45.0
Total	11,387	52.9	10,937	50.8

Source: Derived from Treadwell, *op. cit.*, appendix A, tables 1, 9, and 12.

and the services of skilled social workers were obtained to organize and implement this phase of the psychiatric screening program. A WAC Selection Conference at Fort Des Moines, in July 1944, explained the social history procedure and emphasized the need for such data to appropriate WAC officers in all service commands.

An instructional guide in psychiatric screening was prepared in the Surgeon General's Office and, subsequently, issued on 4 October 1944 as War Department Technical Bulletin (TB MED) 100. This bulletin provided the psychiatrist with background information on the basic training and subsequent life in the WAC. It listed the requirements for enlistment other than physical and psychiatric. It outlined the procedures for, and the problems peculiar to, WAC enlistment. Further, it set forth the objective of the WAC neuropsychiatric examination, which was "to re-evaluate the individual in relation to the new environment, to exclude the unfit individual * * * and to protect the individual from dislocation from her home and introduction into an environment in which she cannot reasonably expect to adjust adequately."

Following this effort to improve psychiatric screening, one of the training centers reported: "The quality of recruit improved; psychiatric problems were reduced and the disability rate was decreased as a result of the * * * procedures." [16]

MENTAL HYGIENE CONSULTATION SERVICES

Fort Des Moines was the first WAC training center, and from its inception in 1942, there was a realistic approach to psychiatric problems, owing in large part to the influence of Maj. Albert Preston, Jr., MC,[17] the chief psychiatrist. Although the need for a mental hygiene consultation service was recognized and efforts in this direction made by both the Director, WAC, and the Surgeon General's Office, 2 years elapsed before it was possible to establish a mental hygiene consultation service at Fort Des Moines [18] and, a few months later, at Fort Oglethorpe, Ga. Major Preston described the mental hygiene consultation services as follows:

> * * *. Originally centered in the Station Hospital at Fort Des Moines, the Consultation Service was moved to the Training Center Area, in June 1946, * * * in close proximity to Personnel and easily accessible to all of the trainees.
>
> The functions of the Consultation Service were to give psychiatric first aid to the enlisted women, trainees, or assigned personnel, through individual and group psychotherapy; give psychiatric counseling to the officers; advise with the commanding officer regarding matters of mental health of the command; give psychiatric consultation service to the Station Hospital, advise with Classification concerning proper utilization of enlisted women; and give talks on Mental Hygiene to officers and enlisted women.
>
> Cooperation between all units of the post was excellent and all assistance possible was given by headquarters to "maintain the mission" of the Consultation Service. Favorable reception of the facilities of the Consultation Service was probably greater

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[16] Preston, *op. cit.*, p. 11.

[17] The material in this section has been drawn either verbatim or with modifications from Major Preston's manuscript (see footnote 4, p. 421), and unless otherwise indicated, quoted paragraphs have been cited from this source.—M. D. C.

[18] Memorandum, Maj. Gen. Norman T. Kirk, The Surgeon General, for Commanding General, Headquarters, Seventh Service Command, Omaha, Neb., (attn: The Surgeon), 10 Apr., 1944, subject: Establishment of a Neuropsychiatric Consultation Service at the WAC Training Center at Des Moines, Iowa.

by women than by men and less resentment was shown to psychiatric referrals. This was illustrated by the fact that 5.4% of all referrals were self referred. Acceptance by the WAC company officers was slow at first, * * * many of the women officers did not like to admit that there were failures of adjustment in their command and felt that the Consultation Service was invading their own advisory fields. Later, this was overcome and 54.3% of all referrals to the Consultation Service came through the basic company commanders. A relatively small number of referrals came through medical channels, 26.9%. All of this may be due to the fact that in women "the socially acknowledged and permitted emotionalism" is accepted and not judged as a conflict, stigma, or weakness, as in men. This accounts also in part for the different manifestations seen in the type of disorders treated in a Consultation Service at a WAC Training Center.

The staff of the Consultation Service consisted of a Psychiatrist (male), Clinical Psychologist, Psychiatric Social Workers (two SSN 263), clerical assistants (three), and a Red Cross Unit made up of a well-qualified Psychiatric Social Worker and a stenographer. This staff worked closely as a team. Upon referral of a case and receipt of the written reasons for the referral, the patient was interviewed by the 263 [social worker] who took a detailed personal, social, and military history. Then a case conference was held with the psychiatrist or psychologist; indicated psychological tests were given, and the case referred to either the psychiatrist or the psychologist. Therapeutic aims were outlined and treatment instituted at the appropriate level, the Company Commander, the 263 [social worker], the ARC [American Red Cross], the psychologist, or the psychiatrist. From 1 to 10 interviews were utilized in treatment, the average number being 2. A small number of cases were referred to the hospital for consultation with other specialties or a brief period of hospitalization. All psychotics and severe psychoneurotics were admitted to the Station Hospital for observation for discharge or transfer to a General Hospital.

Mental Hygiene lectures were given in the Post Theater to groups of one basic company. Three lectures at weekly intervals were given. Better results could have been achieved if the lectures had been given at the platoon level and in closer sequence, since it was seen that better response was obtained when the mental hygiene talks were given to smaller groups. The lectures followed in general the outline of TB MED 21, emphasizing * * * normalcy of symptom development following such disabilities. Attempts were made also to give a simplified developmental psychology of women in an effort to achieve a greater understanding of the basic mechanisms of adjustment and maladjustment in women. These lectures were illustrated by charts, chalk talks, and a group of slides, "Jane and Mame," an adaption for women of "Mack and Mike," done with the permission of Lt. Col. R. Robert Cohen, MC, of Aberdeen Proving Ground, Md.

It became more and more obvious to the officers that as the war progressed the enlisted women needed psychiatric guidance, and frequent calls were made for group counseling by the company officers and by groups of enlisted women.

The Consultation Service worked in close liaison with the Director of Training. Through the study of emotionally disturbed women referred to the Service, recommendations were made which often alleviated the temporary maladjustment of the trainees. These suggestions related to teaching methods and to the interpersonal relationships of the instructor with the student. Group discussions with the cadre and officers were used to point out psychological problems and their solutions.

HEALTH EDUCATION

Because of early unfortunate publicity regarding the moral standards of the WAAC, the Director was extremely cautious about any type of educational material on health matters.

Training Pamphlet

A training bulletin was prepared by the WAAC office, with some medical advice, but it was inadequate. This bulletin, issued on 27 May 1943 as War Department Pamphlet No. 35–1, consisted of six lectures. The pamphlet was described by the WAC historian, Lt. Col. Mattie E. Treadwell,[19] as follows: "This was, however, an unsensational document, part of the routine training course, which prescribed standard subjects no more radical than those given in high schools and colleges—and which said nothing whatever about the issue of contraceptives." This pamphlet sounded more like a moral than a medical discourse, and in the opinion of annoyed medical officers, a more Victorian approach to the facts of life could scarcely have been contrived.

Rumor.—Perhaps the title, "Sex Hygiene Course, Officers and Officer Candidates, WAAC," was unfortunate in provoking curiosity. The pamphlet served to climax a previous whispering campaign about the morals of the Waacs, for on 8 June 1943, the *Washington Times-Herald* published a sensational article which stated, among other things, that "contraceptives and prophylactic equipment will be furnished to members of the WAAC, according to a supersecret agreement by high-ranking officers." This gave fuel to the slander campaign to such an extent that the Army's Military Intelligence Service made an extensive investigation all over the Nation of the rumors and drew the following conclusions as to the origin and source of those stories:

> Army personnel * * * who resent members of the WAAC * * *.
> Soldiers' wives.
> Jealous civilian women.
> Gossips: Thoughtless gossiping men and women. Men [who] like to tell off-color stories.
> Fanatics: Those who cannot get used to women being in any place except the home.
> Waacs: Disgruntled and discharged Waacs.

The intensity of the rumors decreased after testimony before various House Committees and denials by President and Mrs. Franklin D. Roosevelt, Gen. George C. Marshall, and other military and civilian leaders. However, the effect on the future policies in regard to medical education of the WAC was profoundly affected by the Director's fears, and her attitude stemmed largely from this experience.

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[19] The quoted passages in this section are from Treadwell, *op. cit.*, pp. 203–206.

Instructors

There were not sufficient medical personnel to give proper instruction outside of the training centers. Therefore, a plan [20] was devised in the Surgeon General's Office to develop capable instructors from a selected group of about 83 WAC officers, by means of an intensive training course at the Johns Hopkins School of Hygiene, Baltimore, Md., under the title "Preventive Medicine." This course was conducted by outstanding civilian specialists. It included the anatomy, physiology, and pathology of the reproductive system, but the major portion of the time was given to lectures and to discussion groups in psychiatry. The topics were "Psychological Approach," "Normal Psychology of Sex," "Emotional Maturity," "Common Forms of Psychiatric Conditions," and "Sexual Maladjustment."

These officers were then assigned to all WAC installations in rotation to initiate a basic training program in health education to the already enlisted women of the Corps. Subsequently, all such instructions were to be given during the regular training program.

Training Aids and Literature

Efforts were made to have the material from the training course printed for use by the instructors. Approval for its publication was never obtained. In October 1944, however, a simplified but inadequate form for training purposes was made available. Later, in May 1945, War Department Pamphlet No. 35–1 was revised so that it followed more closely the outline of the Johns Hopkins lectures, and this was incorporated in the regular health education courses under the direction of the Training Division of the Surgeon General's Office.

Repeated attempts by the Surgeon General's Office to supply printed or illustrated material for health education, especially concerning psychiatry or venereal diseases, were blocked at different levels of command, including the WAC Director and public relations officials, for fear of misinterpretation by the public. Late in the war, some movies were allowed, and one on personal hygiene was even planned and then filmed in Hollywood, under the supervision of the Surgeon General's Office. Some educational pamphlets were prepared on various medical aspects, including oversea health problems. These were illustrated in cartoon style by professional artists.

UTILIZATION OF WAC PERSONNEL

Objective

The objective of the WAAC was stated to be "for the purpose of

[20] Memorandum, Maj. Margaret D. Craighill, MC, for Director, Preventive Medicine Division, SGO 28 July 1943, subject: Conference on Preventive Medicine, Baltimore, Maryland, 12–18, July 1943.

making available to the national defense the knowledge, skill, and special training of the women of the nation * * * to replace men." [21] This placed the emphasis on the use of qualified women to replace men in jobs requiring skilled workers, especially those in which critical shortages existed. When possible, women with civilian skills were recruited so that only basic military training was needed before assignment. However, this goal was not achieved, and according to Major Preston:

> * * * only 35% were skilled civilian workers, 31% semiskilled, and 34% unskilled. Classification and assignment officers in the WAC had the problem of correlating the military needs, the skills presented by the recruits, the utilization of large numbers of unskilled women and the wishes of women in assignment. Early in the history of the WAAC, Classification and Assignment procedures paid little attention to the desires of the recruits or to their psychological needs.

Classification and Assignment

After the Consultation Service was established at Fort Des Moines, there were frequent referrals by classification officers, which "led to assignments based on the fulfillment of ability, motivation, and psychological suitability for the job. It is well known that to give a person a job she wants, likes, and is able to do is a prime prerequisite for good adjustment and mental health."

For the Wac, particularly in the early days, there was frequent serious doubt in her own mind and in the minds of her associates about the importance of her job in the war effort. She was unhappy because she compared the usefulness of her Army job with what she might otherwise have been contributing in civilian life. It took the Army a long time to learn how to use these women effectively who finally proved their value so well that the demand for their services far exceeded the supply, both in the Zone of Interior and overseas.

Wacs were more difficult to place than men, because all women's assignments were to positions in which training, special aptitudes, or qualifications were required. There were no menial tasks such as continuous KP (Kitchen Police) or orderly work, nor could the untrained be absorbed, as were men, in the great groups of combat troops. Women, thus, came in direct competition with men for skilled jobs and actually replaced them. This was one of the largest causes of friction and jealousy from men. Soldiers so replaced and sent to combat duty naturally resented it, and their hostility was directed toward the WAC rather than toward the less tangible military necessity.

The proper utilization of Wacs was, therefore, dependent on the special aptitudes and intelligence of the women coming from civilian life. While over 80 percent of the Wacs were in the three upper grades of AGCT (Army General Classification Test), the 18 percent who were in the two lowest

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[21] U.S. Public Law 554, Secs. 1 and 12, 14 May 1942.

grades presented problems out of proportion to their numbers because there were no assignments for which they qualified. Also, many of these women were emotionally unstable, and few had a civilian skill which could be utilized successfully by the military service. Special provision had to be made for them.

Training

Several types of programs were given for women of varying potentialities, such as the "Opportunity School," the "Special Training Unit," the "Leadership School," and the "School for WAC Personnel Administration."

Opportunity School.—The purpose of this school was "to give special training to enlisted women who had no skill or use to the Army." [22] Of the 552 women sent to this school, 388 were in Grade IV or V, AGCT. Major Preston commented:

> After psychiatric examination of many of these women it was found that they had been sent to the school as disciplinary problems, or as problems of adjustment, after being transferred from station to station or job to job, rather than as women lacking in skill.
>
> Most of the women resented the name of the school, feeling that "Opportunity" had definite degrading connotations.
>
> Because of the nature of the women sent to the school, plus the low morale and the poor attitude of the students, psychiatric problems were many and administrative discharges frequent. All of these psychiatric problems were based on character disorders, emotional instability, or mental deficiency.

The school was closed in 9 months (on 19 May 1944) because results did not justify its existence.

Special Training Unit.—Just before closing the Opportunity School, another attempt to train women of Grade V, AGCT, was made at Fort Des Moines. Trainees in this grade were sent to a STU (Special Training Unit). In addition, enlisted women who, in their first 3 weeks of basic training, showed unsatisfactory learning ability or aptitude were also transferred to this unit. It soon became the dumping ground into which company commanders sent their misfits. As Preston stated: "The combination of the low intellectual group and the group with maladjustment and behavior problems was the root of many difficulties and created a training situation which could not be combated."

A review of the 425 women trained in STU showed that the largest problem of these women was that of emotional instability. A large number had poor work records, a history of poor civilian adjustment regarding behavior, including arrests, prostitution, and the like. It was necessary to discharge 19 percent of these women for administrative reasons during their training period in this unit.

After investigation by the Military Training Division, ASF, some

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[22] Army Service Forces Circular No. 88, 24 Sept. 1943.

changes were made in methods of administration. The Consultation Service was more fully utilized before assignment in an effort to salvage some of these women.

The situation was later sufficiently relieved by the WAC selection procedure, which reduced the number of women enlisted in Grade V, AGCT, so that the STU could be deactivated. All women in this lowest grade who were subsequently received at Fort Des Moines were immediately referred to the Consultation Service where they were aided in adjustment and assignment, or recommended for early discharge. In this connection, Major Preston remarked: "In a volunteer organization such as the WAC, the problem of women with low intelligence should not exist."

The Leadership School.—An altogether different program, started in June 1944 "to train selected enlisted personnel or potential noncommissioned officers," was known as the Leadership School.

The number of women who attended this course was the same as for the "Opportunity School," but the results were far better. The selection of women was made on the basis of outstanding ability in basic training. The candidates were screened by the Consultation Service, and the selected women were emotionally mature and stable and were thus qualified to help in guiding others. The success of the Leadership School and its graduates as noncommissioned officers in contributing to better training and morale within the training companies fully justified the length of time in training.

The Leadership School was continued for 15 months and was deactivated in September 1945.

School for WAC Personnel Administration.—Another type of training, the "School for WAC Personnel Administration," was established at Purdue University, Lafayette, Ind., in April 1945. This school trained approximately 900 officers in its nine separate classes, each of 3 weeks' duration. The object of the school was to give additional training in leadership, in order to assist the officers in personnel management within WAC detachments and units. The instructors consisted of WAC staff officers (fig. 44) and faculty members of Purdue University. The utilization of the faculty at Purdue University gave the students a civilian intellectual orientation not possible from Army sources: "The recognition of the WAC staff officers of the severity of psychiatric problems, the necessity for understanding of human behavior and adjustment was illustrated by the 15.6 percentage of time allotted to formal lectures on psychology, psychiatry and mental health."

Attempts were made to provide specialized training in courses such as those given in the Cooks and Bakers School, Clerks School, School for Motor Vehicle Operators, and Medical Technicians School. The details of training in the various programs will not be considered here except to point out some of the psychological concomitants. There was an adverse effect upon morale of trainees who developed an "attitude that attendance at any of these was an unnecessary delay from a field assignment." This was especially

FIGURE 44.—Conference, WAC Staff Directors, Major Commands, Fort Des Moines, Iowa, 18 September 1945. First row: Maj. Evelyn B. Nicholson, Maj. Susan Cornick, Maj. Marion C. Lichty, Lt. Col. Geraldine P. May, Capt. Katheryn Painton, Capt. Shirley Odell, Maj. Grace M. Barth, Col. Westray Battle Boyce, Lt. Col. Helen H. Woods, Maj. Helen Hedekin, Maj. Margaret E. Perry, Maj. Ruth Kerr, Maj. Alice W. Brown, Lt. Col. Mary A. Hallaran. Second row: Maj. Eleanor J. Garber, Lt. Elizabeth Hatch, Lt. Eleanor Walker, Capt. Lucille Tombs, Lt. Col. Emily C. Davis, Capt. Esther Pease, Lt. Col. Mary Louise Milligan, Maj. Frances A. Clements, Capt. Virginia Phelps, Maj. Edith Toffaletti, Maj. Alice McNiff, Maj. Dorothy Harms, Capt. Arlene G. Scheidenhelm, Lt. Col. Anna W. Wilson, Maj. Mirium Riley. Third row: Lt. Col. Florence K. Murray, Maj. Louise K. Smith, Maj. Helen Gardiner, Maj. Elizabeth Gilbert, Maj. Elizabeth Stearns, Maj. Jessie Morris, Maj. Helen T. Walthall, Maj. Wilma Hague. Fourth row: Maj. Helen Hart, Maj. Katherine Marshall, Maj. Celestina McKay, Maj. Treila M. Welch, Capt. Barbara Rhode, Lt. Rita V. Nash, Capt. Margaret West. Fifth row: Capt. Agnes Oberwortman, Lt. Col. Mary C. Freeman, Maj. Gwendolyn Watson, Lt. Col. Cora Webb Bass, Lt. Col. Jessie Pearl Rice, Lt. Col. Katherine R. Goodwin, Lt. Col. Dorothea A. Coleman. Sixth row: Capt. Helen Magoon, Capt. Sara R. Martin, Lt. Col. Betty Bandel, Maj. Jack S. Phillips, Maj. Pauline Linch, Lt. Col. Mary Agnes Brown. Seventh row: Maj. Elizabeth E. Hardesty, Capt. Helen Westerdale Wood, Capt. Emily U. Miller, Maj. Doris E. Epperson, Lt. Col. Elizabeth C. Strayhorn.

true if the school assignment corresponded to the previous civilian job from which the woman was trying to escape by enlistment in the WAC.

Cooks and Bakers School.—This attitude was particularly noticeable in the Cooks and Bakers School where high sick call rates and minor psychiatric casualties resulted from lack of interest and motivation. Other adverse factors were the lack of orientation as to the need for cooks, the low intelligence of 50 percent of the students, in whom there was a high incidence of emotional instability, and the resentment of other student women with higher intelligence to the assignment. The fact that these women

were used only in WAC messes made them feel less useful to the war effort than those who were "replacing a man."

School for Motor Vehicle Operators.—One of the most satisfactory schools was the one for motor vehicle operators, in which approximately 3,000 women trained. Preston commented on this, as follows:

> Little screening for emotional stability or intellectual ability was done. Difficulty was experienced by the assignment of personnel with low AGCT scores who could not make dependable drivers. Although assignment of the personnel to the school, without screening can be criticized, the low sick call rate, 45% of drivers not going to sick call in a six-month period and 40% going only one time in the same period, the minimum psychiatric referrals, the lack of serious menstrual difficulties other than irregularity and the presence of the least amount of fatigue in a comparative study of fatigue in occupations illustrates the advantage of assignments fulfilling motivation for enlistment. However, this led to the development of marked masculine traits and unwarranted criticism of the women drivers because of their masculine uniforms, appearance, and mannerisms.

Medical Technicians School.—From the Wacs' viewpoint, the Medical Technicians School was the most successful program. Over 7,000 women were enlisted in a 4 months' period after the Battle of the Bulge in 1945, for "the opportunity to enlist as a medical technician was grasped by numbers of women who desired hospital training and experience, who had relatives among the casualties, and who were motivated to 'help the suffering'." These women were encouraged to enlist by the guarantee of a technician, fifth grade, rating upon successful completion of their training and of the opportunity to choose a hospital near their home. The high initial ratings caused resentment in other enlisted men and women. Some of these new recruits lacked intelligence, education, and ability. About 20 percent were in the two lowest AGCT grades.

Of the 7,084 women trained in the Medical Technicians School, "there were only three AWOL's [absent without leave], 228 failures, and 360 discharges for various reasons; that is, 8.2 percent of eliminees."

Fatigue Study

Research design

In 1945, just before and after V–J Day, an effort was made to evaluate WAC assignments in the field in relation to fatigue through a study conducted under the direction of the Surgeon General's Office.[23] A sample of 4,572 WAC enlisted personnel, divided proportionately among the Army Ground, Army Service, and Army Air Forces, were interviewed by a survey team; each Wac then completed a questionnaire. Fatigue was defined

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[23] Memorandum, Capt. Miriam Mills, MC, Assistant, Women's Health and Welfare Unit, for Chief, Professional Administrative Service, 5 Dec. 1945 (approved by Lt. Col. Margaret D. Craighill, MC, Consultant, Women's Health and Welfare Unit), subject: Study of Factors of Fatigue Influencing the Effectiveness of WAC Personnel.

as a state of weariness which does not respond to the usual form and amount of relaxation. It was divided into physical and psychological fatigue.

Results

Physical fatigue was found to be related to age, military occupation, and working and living conditions; psychological fatigue, to morale factors such as interest in work, family responsibilities, and promotion. Many health factors, including changes in general health and the influence of nervousness, depression, sick call visits, dysmenorrhea, menstrual irregularity, and alcohol consumption, were also considered in fatigue. Nervousness and depression were not defined, but the presence, increase, or decrease of these conditions, by age group, was ascertained objectively by replies to specific questions. Increased nervousness and depression were over twice as frequent in the group under 40 as in those over 40. The age group of 40 years and over showed a marked decrease in the proportion of women claiming fatigue. General health and various specific health conditions showed the same improvement after the age of 40. This was probably due to the fact that disability rates in this age group had been very high, and therefore, those who remained in service had survival qualities above the average.

The presence of fatigue was manifested in 38.7 percent of those interviewed. Among the six occupational groups used in this study, cooks and mess attendants indicated the most fatigue (48 percent) and drivers the least (31 percent). The mess personnel, however, showed the least incidence of depression and nervousness. The occupational conditions, including types and hours of work, were closely correlated with fatigue. Subsidiary to these factors were environmental living conditions.

From the various factors considered, it was apparent that the incidence of fatigue was influenced more by psychological than physical factors. Interest in the job outweighed all other single factors in importance. There was a general upward trend in fatigue with increased time in service, with the greatest change occurring at the end of 6 months of service.

The association between health and fatigue, as demonstrated by the factors considered for both, was very close, and the results of the study were remarkably consistent.

OVERSEA ASSIGNMENT

This section has been written almost exclusively from the experience and reports of the author based primarily on observations made in the various theaters of operations during an inspection, covering the last quar-

ter of 1944 and the first 6 months of 1945.[24] The survey started in the European theater and was completed in the South Pacific Area, so that it preceded by only a few months the actual end of hostilities in the various zones. For example, France was visited in the period about 6 weeks after the Allied occupation of Paris and within 2 weeks of the Battle of the Bulge. In a comparable situation, the Southwest Pacific Area was seen at approximately the same period after the recapture of Manila in the Philippines, and about 2 months before the defeat of Japan. These observations showed the influence on personnel of newly occupied territory still in combat zones. Other equally as important from the psychiatric viewpoint was the reaction of those individuals "left behind" by the onward sweep of the war in such areas as Africa and Australia. England, Italy, and India might be considered as intermediate areas in that they were all active zones administratively, although for the most part they had passed through the combat phase. On the other extreme were such isolated locations as Burma and China in which the Americans and British had been pushed back and where the commands were poised to reconquer lost territory.

Morale

The aforementioned status of military operations was an important factor affecting the state of morale of Army Wacs, which was also influenced by the length of time overseas, the living and working conditions, the recreational facilities and needs, and the sense of usefulness in promoting the war effort.

Health.—The state of morale was reflected in medical conditions as noted in sick call, hospitalization and evacuation rates, and especially in the specific incidence of such diagnoses as psychoneuroses and pregnancy, which were the major causes of evacuation in most theaters.

In the less tangible conditions of fatigue, dysmenorrhea, and headache, there were also noticeable differences, according to the morale factors. This was observed in various areas and was more accurately noted by the study from a questionnaire filled out by women, both nurses and Wacs, in India and Burma. Another indicator of morale was evident in the increased frequency of specific medical conditions, such an anemia, malaria, dysentery, and dermatitis. Many of these conditions reflected the woman's own habits and personal precautions, which were influenced by her state of emotional adjustment.

Climate.—The extremes in climate affected the emotional as well as

[24] Memorandums, Maj. Margaret D. Craighill, MC, for The Surgeon General, as follows: (1) 30 Nov. 1944, subject: Health Conditions of Nurses and Wacs in ETOUSA. (2) 1 Jan. 1945, subject: Health Conditions of Nurses and Wacs in MTOUSA. (3) 8 Jan. 1945, subject: Health Conditions of Nurses and Wacs in USAFIME. (4) 27 Jan. 1945, subject: Health Conditions of Nurses in Persian Gulf Command. (5) 11 Mar. 1945, subject: Conditions Affecting Women Personnel in China. (6) 30 Mar. 1945, subject: Medical and Social Conditions of Women in Military Service in the India-Burma Theater. (7) 6 Apr. 1945, subject: Medical and Social Conditions of Women in Military Service in Ceylon. (8) 8 June 1945, subject: Medical and Social Conditions of Women in Military Service in Southwest Pacific Area.

the physical reaction of individuals. This was observed specifically in the Persian Gulf area, which had the most intense dry heat, and in Burma, especially during the monsoon season, with extremes of humidity and heat. Marked apathy, depression, and fatigue were characteristic of the personnel in these locations, and the intensity of discomfort was an index of the person's state of morale. Extremes of cold or heat were better tolerated, if not accompanied by rain. This was observed in northern France where the cold, with rains and flooding, was so demoralizing, as compared to northern Italy where the cold was present with dry snow and ice. When clothes and bedding were constantly wet, when shoes mildewed, and when mobility was limited by floods, the morale of units deteriorated.

Age and time overseas.—Length of time overseas and age were very important factors in withstanding hardships. The incidence of medical evacuations, particularly for psychoneuroses, was highest in the older age group. It was the opinion of many medical officers that, with few exceptions, women over 35 should not be sent overseas. Also, that after 18 months of oversea service, there was a definite tendency toward increase in morbidity and medical evacuation.

Work satisfaction.—Practically all the observations mentioned, thus far, applied to women personnel in whatever component of the Army. The nurses showed more variations because they had been overseas for longer periods, but the trends were much the same. The theme was repeated, over and over again, that environmental conditions were less important than satisfaction in the job, whether in oversea service or in the United States. The best morale was noted among those women, in active combat areas, who were working hard on assignments which were obviously important and in which they felt needed.

Group solidarity.—A comparison of two WAC units in the U.S. Army Forces in the Middle East brought out very interesting contrasts relating to group solidarity. The WAC unit at Cairo, Egypt, was composed of 139 women who had been overseas for 19 months and had good morale. It was considered a well-adjusted group with only minor emotional problems, largely due to frustration at being in an inactive war zone. This unit had made provisions for informal activities, including a workshop in the barracks equipped with tools for carpentry or the finer arts.

Another WAC unit of 157 women at Accra, West Africa, had been overseas only 3 months. They had been sent overseas before many of them had been in the Army long enough to become adjusted. The group had been together only 2 weeks before oversea shipment and had arrived at Accra in small groups. They never became amalgamated into a cohesive unit and did not even know the other women in their company. The women had no duties or responsibilities other than office jobs, because their quarters, laundry, and mess were taken care of by native servants. This group, then, was introduced into an isolated camp of several thousand men who had been overseas for a long time, and who were eager for the companion-

ship of American women. Thus, they were precipitated into a situation of great competition for their society. It was not surprising that some Wacs took full advantage of this unusual opportunity and remained stable; while others, unable to handle the situation, "cracked up" under the strain (see p. 455). Drinking was reported as habitual and excessive. Psychiatric conditions were already a major problem. Two women had been sent back for neuropsychiatric causes, and it was estimated that more would follow, until the group became stabilized and adjusted to the environment.

Living Conditions

There were Wacs in all the theaters of operations visited during the survey, except in the Persian Gulf area, Burma, and China. Also, there was a group in Ceylon, and later, some Wacs were stationed in China. As of December 1944, there were in all oversea theaters some 13,817 Wacs (officers and enlisted women), as follows: European theater, 5,931; Mediterranean theater, 1,576; Africa and Middle East, 252; China-Burma-India, 326; Pacific areas, 4,343; and other, 1,389.[25]

There were many similarities in the living conditions of the various theaters. In general, Wacs had better living accommodations than nurses in comparable locations. There were some exceptions. The Wacs in the forward zone with the Fifth U.S. Army in Italy lived in pyramidal tents and had much the same quarters as did nurses. Elsewhere, Wacs were quartered, insofar as possible, in already existing buildings, such as apartment houses, schools, barracks, or hotels. Some of these accommodations were quite luxurious.

By contrast, where no fixed facilities were available, as in the Southwest Pacific Area, tents or prefabricated huts, with or without floors, were used, according to terrain or military necessity. Overcrowding was common. Outside latrines, in blocks with no separating partitions, and open showers were installed with no opportunity for individual privacy. Except in such primitive areas, dayrooms and date rooms were usually provided, as were laundry facilities and hairdressing arrangements.

Unusual living conditions were established in Hastings Mill, outside Calcutta, India, where all 256 Wacs were housed together in one big barracks, which had been a jute mill. WAC officers' quarters, one room for sickbay, and a room for the cooks were all separated by partial partitions of hemp cloth. These crowded conditions produced tension which showed in instability and depression, but these symptoms were offset by the feeling of doing a good job in a situation in which they were needed.

Working Conditions

The working conditions varied somewhat in the different commands.

[25] Treadwell, *op. cit.*, appendix A, table 7.

In most areas, Wacs were assigned to headquarters units as clerks, or to communications, and were not overworked. In fact, there were many complaints about insufficiency of work, especially in some rear areas.

Two special groups of Wacs exhibited the effects of occupational strain. One was a Signal Corps detachment working with the British in Ceylon. This group of 14 women had been in this organization for about a year and had worked shifts around the clock, rotating every 4 days. A high incidence of illness occurred among them; 10 of the Wacs had an average of two hospital admissions each, and the other 4 had a record of many sick calls. Their difficulties were attributed to irregularity in meals and to loss of sleep due to interruptions in the normal sleep cycle because of constantly shifting hours of work.

The other instance of occupational stress was found in a group of WAC officers serving a censorship function for the Southwest Pacific Area, on the island of Biak. Examinations, after a year, showed that over one-half had marked visual disturbances. An additional psychic trauma to these women was the pornographic material in the letters and the complaints of the men, particularly about marital problems. No special criteria of personnel selection had been used in choosing the WAC officers for this assignment, which obviously required considerable emotional maturity and stability.

Recreational and Leave Facilities

Provisions for recreation were particularly important in isolated areas, especially where the women's activities were so largely restricted to their own quarters. For example, in New Guinea and on Guam, Wacs and other female personnel could not leave their housing areas after dark except with an armed escort. In all locations, there were more than enough dances, but the competition among the men for partners became so great, and the demand for the company of women so intense, that the girls soon tired of this form of group activity and would refuse dates except on an individual basis. The women missed the familiar things, such as hot dogs and Coca-Cola, and found themselves instead drinking alcoholic liquors for sociability or because of urging by the men. Many Wacs were unfamiliar with alcoholic drinks and their inability to know their capacity, especially in hot climates, was sometimes disastrous. The lack of dayrooms in which women could gather together for sociability or of date rooms where they could properly receive male friends caused many social complications and resulted in morale problems. The WAC unit in Cairo, with the high morale, had both dayrooms and date rooms; the unit at Accra had neither.

The provision of rest areas for women was less common than it was for men, except in the European theater. Here, a unique rest home, called the Rookery, in Oxford, England, was operated by Wacs for the rest or convalescence of enlisted women. In Italy, there was a rest area on the

island of Capri. WAC officers could go to certain hotels, but in Rome the only hotel for women was not popular. WAC officers, like nurses, usually preferred a general hotel to a segregated rest home. There was definite resentment among women officers to the attitude of protection and mistrust. They wished to be treated like adult individuals, responsible for their own conduct.

Rotation policies did not affect the Wacs because they had not been overseas for a sufficient length of time. The first Waacs, a group of five officers, went to North Africa in December of 1942, by ship which was torpedoed in transit. The first WAC unit with enlisted women arrived in North Africa a month later, and from then on the total oversea WAC strength was built up to a maximum of 17,035 by July 1945.[26]

Social Situations

Both men and women suffered from extreme lonesomeness in unfamiliar surroundings which resulted in quick friendships and marked dependence on one person, either of the same or of the opposite sex. Married men, especially, missed their wives and were prone to make liaisons with women who perhaps might not have seemed so attractive under other or more normal circumstances. It was hard for some Wacs to maintain objectivity and emotional balance and to remember that circumstances rather than their own charms were responsible for such popularity. The social pressure on Wacs by large numbers of lonesome men was "terrific." Many methods from command attendance to extravagant inducements were used to secure their companionship. The tension of keeping up with work and with too much social activity, as well as the stress of emotional conflict required by these relationships, was the cause of many psychiatric disturbances. The social situation was particularly difficult among members of male and female units long isolated together, who became very dependent on one another. Their past and future lives were vague and unreal, and only the present was of importance. The present was viewed as an interlude in life and whatever made it more bearable seemed justifiable. Men were apparently better able to partition off this segment of their lives so that they did not as readily become deeply or permanently emotionally involved. They were, therefore, less liable to lasting psychic trauma from these intense but temporary attachments. Some of these relationships continued after the war, but most were severed, sometimes with tragic sequelae, especially to the women involved.

Medical Evacuations

The two leading medical causes for evacuation in all oversea theaters were psychiatric disorders and pregnancy.

[26] Treadwell, *op. cit.*, p. 772.

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Psychiatric disorders

There was a tendency among medical officers everywhere not to "stigmatize" a woman with a psychiatric label, if any other diagnosis could be used. There was, however, a need for some type of combined administrative and medical procedure whereby those Wacs clearly unsuited for oversea service could be returned before they became completely unfit for duty, even in the Zone of Interior.

In the European theater, 11 percent of medical evacuations among the Wacs were for neuropsychiatric conditions; in the Mediterranean theater, it was 27 percent. These were the two theaters which had the most Wacs who had the longest oversea service. In the Southwest Pacific Area, with an average strength of about 5,200 Wacs, the rate was 27 per 1,000 per annum. In the Southwest Pacific Area, the factors involved were as follows:

1. Inadequate psychiatric screening on enlistment.
2. Poor selection for oversea duty by sending misfits and women who did not want oversea duty.
3. Misassignment of trained personnel.
4. Disillusionment about oversea duty.
5. Frustration due to lack of work or the relative importance of a job.

Pregnancy

In the various theaters, over one-half the medical evacuations were for pregnancy. In the European theater, there were 56 percent. In the Southwest Pacific Area, for a period of 9 months, the rate per 1,000 personnel per annum was 19.82. Of the approximately 26,000 American women in military service in the European theater, the rate was 2.2 per 1,000. In all areas, the rate increased with length of time overseas. The varying marriage policies in the theaters seemed to have had little effect on the pregnancy rate. It was unofficially stated that approximately one-half of the oversea Wacs were married. In the European theater, there was an arbitrary geographic separation of married couples within the theater. In Italy, the fact of intermarriages between officers and enlisted women, or vice versa, was recognized to the extent that, in social conditions, the husband's military status took precedence, this even applying to billeting in hotels or leave areas. In the India-Burma theater, marriages of Wacs were not allowed until about the end of the war, on penalty of fines and other forms of punishment by court-martial. In almost all areas, there were some pregnancies discovered overseas which had occurred before leaving the United States. In one such case, the WAC commander in the Zone of Interior had asked for discharge of the woman before oversea shipment.

The method of handling the return of pregnant female personnel to the Zone of Interior caused them some embarrassment. These women were returned through the medical evacuation chain with the diagnosis of preg-

nancy entered on the jacket of the field medical records which had to be shown on demand. Also, on some ships, the patient list, including diagnosis, for embarkation was also the official passenger list. This procedure was corrected with the issuance of WD Circular No. 430, on 22 September 1944.

Information on the incidence of self-induced abortions was probably inaccurate, but patients with sequelae of hemorrhages or infections were relatively rare. In fact, there was an apparent trend toward pregnancy as a means for getting home rather than an effort being made to terminate an otherwise unwanted pregnancy.[27] The occurrence of venereal disease was also probably much higher than the officially recorded rates which increased markedly after the Wacs moved to Paris.

Selection

Originally, selection of Wacs for oversea duty was on a volunteer basis, but this policy was not followed consistently, as the need for special work assignments increased. Volunteers adjusted better than those who came unwillingly. One of the most apparent and frequent sources of difficulty noted in all theaters was the deficiency of psychiatric and medical screening before oversea shipment. Many women had inadequate examinations on enlistment because of the pressure of recruiting. Even had better initial examinations been required, many conditions might have been overlooked or might have developed after coming into service, which would not necessarily have been apparent without further examination after entry into the service. An additional source of stress was that female military personnel were more conspicuous than the male military personnel in oversea theaters, and any deviation from the normal was emphasized out of proportion to its usual importance. Also, overseas, women were subject to more tension than men, because of their relative scarcity, their more restricted personal freedom, and their increased emotional pressure, as already described.

THE PSYCHIATRIC PROBLEM

Diagnostic Categories

Reiterating, of the major diagnostic categories, psychopathic personality and psychoneurosis were the major causes of rejection of Wacs for military service (table 36). The same might have been true of the discharges for disability, except that character and behavior disorders were not differentiated in these instances as such, and were included presumably under psychoneurosis (tables 40 and 43). Psychoses were by far less frequent. It is estimated that, of the Waacs discharged for disability during

[27] Some 11,000 Waacs and Wacs were discharged from the service for pregnancy, constituting 8.0 percent of all separations (tables 46 and 47).

the 10-month period from August 1942 through May 1943, some 450 Wacs (38.2 percent, table 40) were discharged for psychoneurosis, and of the Wacs discharged for disability from August 1943 through December 1944, some 2,200 (44.3 percent, table 43) were discharged for psychoneurosis.[28]

An analysis[29] of the diagnoses of 7,639 patients seen in the Mental Hygiene Consultation Service at the First WAC Training Center at Fort Des Moines is shown as follows:

Diagnosis	*Percent*
Psychoneuroses:	
Anxiety	5.01
Gastric	.18
Cardiac	.29
Hysteria	3.01
Obsessive compulsive	1.22
Unclassified	4.70
Total	14.41
Psychoses:	
Schizophrenia	2.27
Manic depressive	.43
Total	2.70
Character disorders:	
Nocturnal enuresis	0.59
Psychopathic personality	7.60
Cyclothymic personality	1.60
Schizoid personality	2.54
Lack of adaptability	1.10
Personality problem	2.03
Emotional instability	2.40
Alcoholism	.76
Total	18.62
Neurological:	
Organic	0.70
Epilepsy	.55
Total	1.25
Mental deficiency	19.18
Maladjustment:	
Situational	17.36
Assignment	2.70
Personal	1.90
Absent without leave	8.80
Total	30.76

[28] Dr. Bernard D. Karpinos, Assistant for Manpower Studies, Medical Statistics Agency, Office of The Surgeon General, in his statistical review of this chapter, 24 Nov. 1964, commented, as follows: "There are no data on the diagnostic distribution of the separations for disability after October 1944. Should we assume that the neuropsychiatric diagnosis of those discharged for disability after October 1944 through December 1946 were the same as those for the October 1943 through October 1944 period (table 43), then the estimate is that of all the WAAC and WAC separations for disability (table 46), 6,300 Waacs and Wacs were discharged for neuropsychiatric disorders, among whom 5,000 Waacs and Wacs were discharged for psychoneurosis."

[29] Preston, *op. cit.*, pp. 37–38.

Diagnosis—Continued	*Percent*
Medical conditions:	
Organic	2.00
Syphilis	.13
Menstrual	8.23
Pregnancy	.72
Total	11.08
Administrative (miscellaneous)	2.00
Grand total	100.00

The following shows the disposition of these 7,639 patients:

	Percent
Return to duty	60.60
Reassignment	12.00
Certificate of disability for discharge	3.90
Hospitalization	6.20
Discharge under the provisions of AR 615–368 [Unfitness]	3.20
Discharge under the provisions of AR 615–369 [Inaptitude or unsuitability]	10.00
Minority	2.75
Dependency, resignation, death	1.35
Total	100.00

Infrequency of certain conditions.—Two conditions which were serious problems with men were negligible for women. Enuresis was almost never found. Why there is so much sex difference in this symptom has not been satisfactorily explained. Also, homosexuality was much less of a problem than was expected. It was anticipated that military life might attract overt homosexuals, but this was true only to a very limited extent. When homosexuals were found, they created a more difficult situation than with men, but too frequently a worse problem was that of false rumors and witch hunting. Any girl with marked masculine tendencies or any two girls with close friendships were under suspicion and practically convicted by a whispering campaign with little opportunity to defend themselves. There are no available records on discharges for homosexuality. Any such discharges were probably classified under some other category. Instruction on the subject was considered, and in a communication dated 7 September 1944, the following policy was recommended by the Surgeon General's Office:[30]

1. It is the opinion of this office that instruction to the WAC in homosexuality should not be emphasized.

2. It is recommended that the psychiatrists in charge of the Consultation Service at the Training Centers incorporate the subject in the lectures on Personal Adjustment Problems now currently given in compliance with WD Circular No. 48, 1944, according to TB MED 12 and 21.

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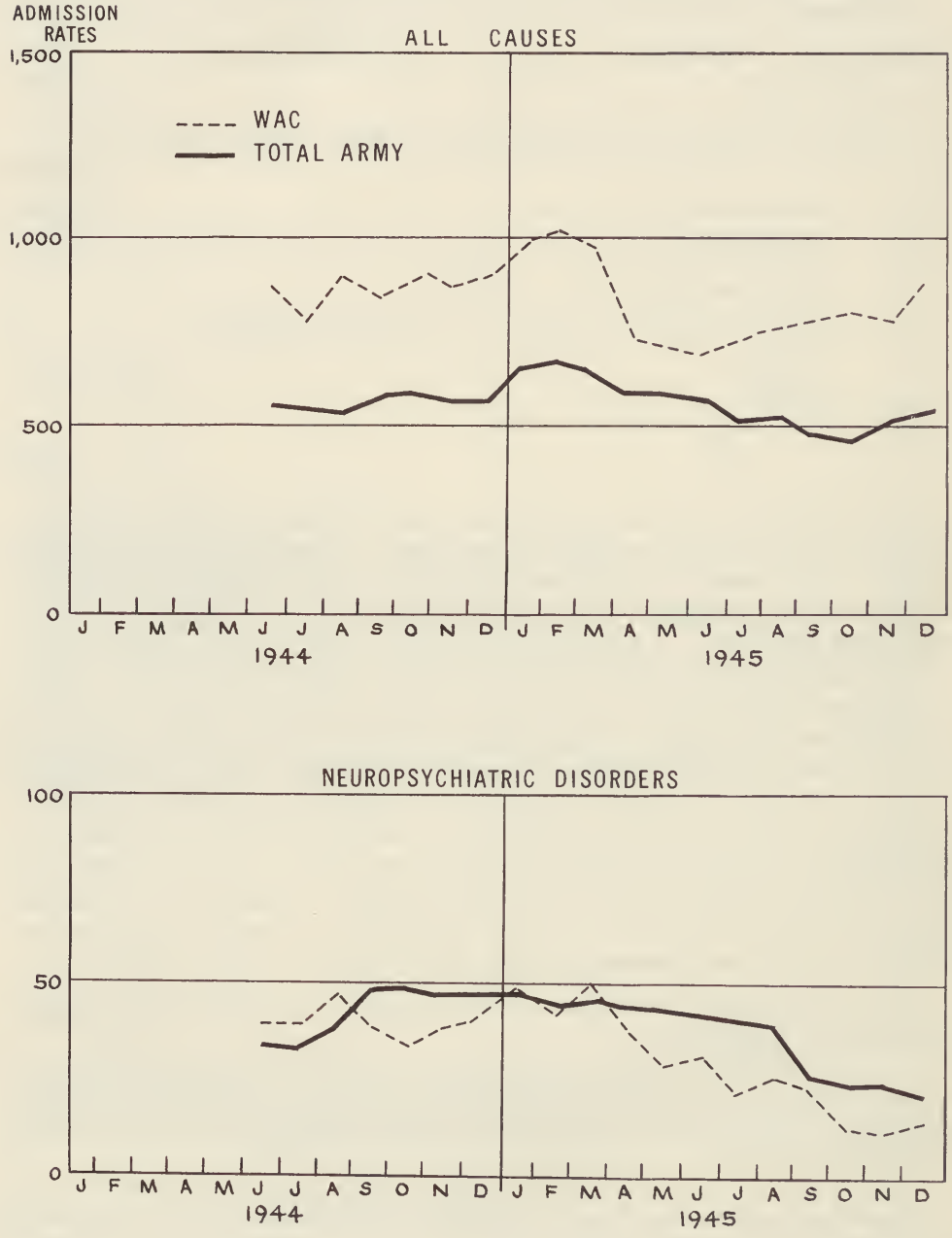
[30] Letter, Col. Oveta Culp Hobby, The Director, WAC, to Commanding General, Army Service Forces (Attn: Director, Military Training Division), 26 Aug. 1944, subject: Course of Instruction on Homosexuality, with 2d endorsement thereto, 7 Sept. 1944.

CHART 13.—*Admission rates for total Army and for Wacs, for all causes and for neuropsychiatric disorders, June 1944 through December 1945*

[Rate expressed as number admitted per 1,000 mean strength per year]



Hospitalization Rates

Only partial data are available in regard to the health of the Wacs while in the service. Such available health data, in terms of hospital admissions, are presented in table 48 and graphically shown in charts 13 and 14. The admission rates, expressed as the number admitted per 1,000 mean strength per year, are shown for both the WAC and the total Army, for comparative evaluation. The admissions are given separately for all causes and for neuropsychiatric disorders.

The data on admissions for all causes clearly indicate higher rates for Wacs. This holds true throughout the entire period. It seems that these higher rates were due mainly to higher incidence of common respiratory diseases, influenza, diarrhea, and dysentery among Wacs (see chart 14).

CHART 14.—*Admissions for all Army personnel and for the WAC, in the United States, June 1944–December 1945*

[Rate expressed as number admitted per 1,000 mean strength per year]

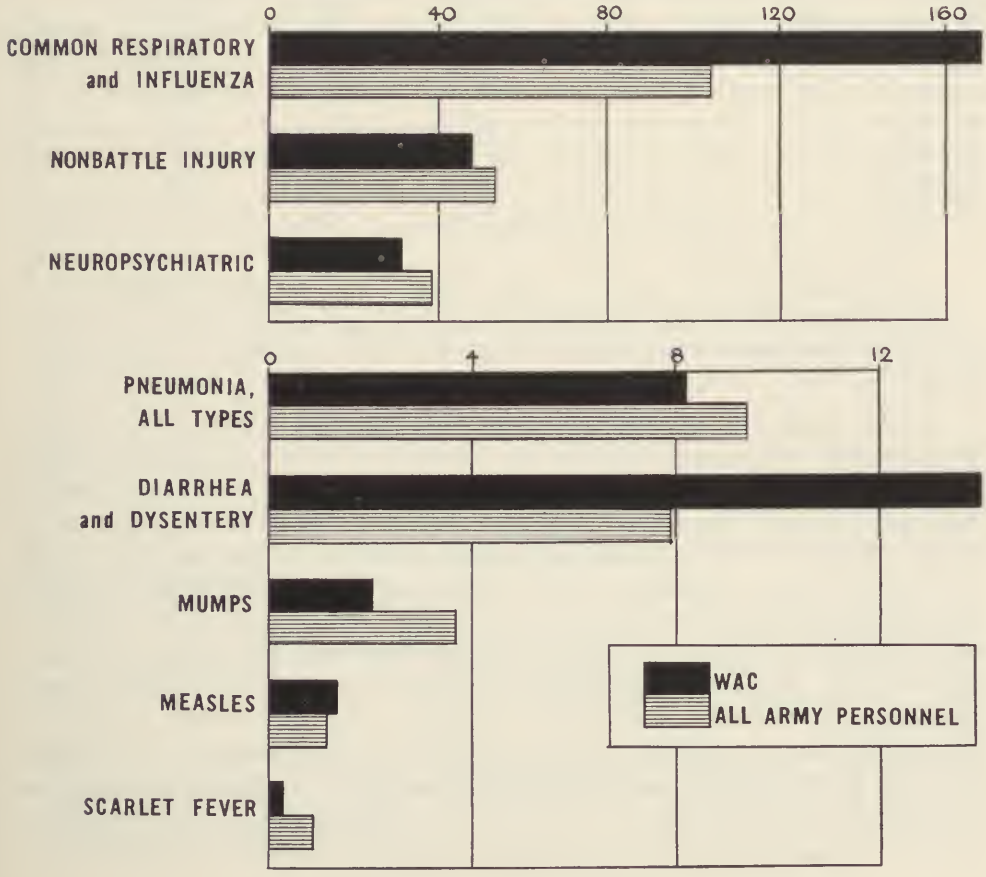


TABLE 48.—*Admission rates for total Army and for Wacs for all causes and for neuropsychiatric disorders, June 1944 through December 1945*

[Rate expressed as number of admissions per 1,000 strength per year]

Year and month	All causes		Neuropsychiatric disorders	
	Total Army	Wacs	Total Army	Wacs
1944				
June	553	898	33	38
July	544	786	32	38
August	543	903	36	46
September	572	849	46	37
October	578	901	48	33
November	558	875	47	37
December	568	906	47	41
1945				
January	660	995	47	48
February	677	1,003	44	42
March	648	981	46	50
April	595	742	44	37
May	591	719	43	28
June	568	706	41	31
July	519	755	39	21
August	522	769	37	26
September	478	795	25	22
October	474	821	23	12
November	502	798	23	10
December	535	893	21	13
Total average (1944–45)	566	856	39	34

Source: Derived from data published for (1) Total Army: Morbidity and Mortality in the U.S. Army, 1940–45; and (2) Wacs: Weekly Health Reports, 7 July–29 Dec. 1944; 5 Jan–29 June 1945; 6 July–28 Dec. 1945; and 4 Jan.–27 Dec. 1946; Office of The Surgeon General.

With respect to admissions for neuropsychiatric conditions, no trend can be noted. In certain months, the admission rates of Wacs for neuropsychiatric disorders were higher than those for men; in other months, they were lower. There was a definite decline in the neuropsychiatric admission rates of Wacs toward the end of 1945. It is possible that these lower rates were a reflection of the ending of the war—a trend that was demonstrated after V–J Day in the fatigue study previously described. Most of the admissions of Wacs for neuropsychiatric reasons were for relatively minor emotional disturbances and did not require prolonged hospitalization.

For the whole period, for which health data are available, the admission rate for all causes was 856 for Wacs and 566 for the total Army, per 1,000 mean strength per year. The WAC admission rate for all causes was thus somewhat above 50 percent higher than that of the total Army. The

admission rate for neuropsychiatric disorders for this period was 34 for the WAC, as compared with 39 for the total Army (table 48). (See chart 14 for comparative rates of Wacs and the total Army, for selected diagnoses.)

Associated Medical Conditions

Dysmenorrhea

Dysmenorrhea was not given special consideration by the Medical Department because it was deemed more advisable to consider it as a normal psychological function and not to encourage feelings of disability. Exercise and the regular pursuit of work were recommended except in unusually severe cases. In many of these, a large psychological component was recognized.

Pregnancy

Pregnancy was a cause of discharge as soon as certified by a medical officer. The early WAAC policy [31] was separation from the service with an administrative honorable discharge, regardless of the origin of the condition. This was a very wise and humane regulation but was not adopted by the Army Nurse Corps until sometime after incorporation into the Army of the United States. Finally, with extreme reluctance, the administrative honorable discharge for pregnancy was accepted as the policy for all women components of the Army.[32] Illegal abortion, however, was "regarded as misconduct."

A related problem of providing maternity care was also opposed by the Army Nurse Corps as well as by many persons in the War Department. It was, however, endorsed by The Surgeon General and by the Director, WAC, and after 2 years' effort, War Department Circular No. 430 was finally issued in late 1944. This directive also provided for the care and return from overseas of pregnant military personnel and for the care of their babies, if necessary. These controversial issues aroused great emotional reactions in many persons in positions of authority, whose prejudices and fears influenced them to take a moralistic and punitive viewpoint rather than a broad medical and social one.

The loss of personnel because of pregnancy was high. Discharges for pregnancy were more frequent than for all other medical conditions combined. This is evidenced by the data presented in table 47. In 1944, the discharge rate of Wacs for pregnancy was 51.5, as compared with 44.1 for disability, per 1,000 mean strength per year. In 1945, the discharge rate was 70.5 for pregnancy, compared with 53.5 for disability, and in 1946 the

[31] WAAC Circular No. 17, 29 Dec. 1942.
[32] Army Regulations No. 40–20, 9 Jan. 1944.

discharge rates were 45.0 and 22.5 for pregnancy and disability, respectively. Altogether, the total number of Waacs and Wacs discharged for pregnancy was about the same for disability: 10,937 for pregnancy and 11,387 for disability (table 47).

As the war continued, some women were restless because they were getting older and wanted to have children before it was too late. Some, who had previously considered themselves sterile, were able to achieve pregnancy when they rejoined their husbands after separation in the Army. This was apparently influenced by the more regulated and routine life in the WAC as well as by the heightened pleasurable anticipation of reunion. Others saw pregnancy as a means of leaving the Army. Many had unplanned pregnancies, either with or without marriage. This was especially true in oversea areas where groups of young women were closely associated with men isolated together in tension-charged situations. The inevitable result was, frequently, marriage. These women were willing to forego pregnancy for a short period of time, but as the war dragged on, many became increasingly impatient to start a family. Some used pregnancy as an excuse for return from overseas. Others, as in civilian life, were swept away by strong emotions, especially under the added stress of oversea life. In one theater, marriage between Army personnel was prohibited unless pregnancy had occurred. The result was the highest illegitimacy rate of any oversea command, until the regulation was changed in April 1945.[33]

Menopause

With the increasing age group of the WAC, the problem of how to handle women with symptoms attributed to the menopause became urgent. Reports from the field medical installations showed considerable confusion. It soon became evident that the diagnosis of menopause was being used rather indiscriminately, covering many conditions of a psychiatric nature, as well as gynecological disorders. Policies of diagnoses, treatment, and disposition were recommended as early as August 1944, but it was not until May 1945 that TB MED 158, covering the subject, was issued. In this bulletin, the psychiatric components were emphasized, and it was stated: "Separation because of menopausal syndrome should not be accomplished without consultation with an internist, a gynecologist and a neuropsychiatrist, when such specialists are available." A 6 months' treatment program was recommended before considering discharge for menopause.

Venereal diseases

The problem of control and incidence of venereal diseases in the WAC was psychological as well as medical. Problems developed early in relation

[33] Personal communication, Lt. Gen. Don J. Sulton, to Maj. Margaret D. Craighill, MC, 26 Apr. 1945, subject: Marriage Policy.

to the inclusion of Wacs in the prescribed monthly physical inspections for venereal diseases that were required for men. The confusion was finally resolved with the issuance, on 1 January 1944, of Circular Letter No. 1, Office of The Surgeon General, outlining an acceptable procedure for women. Educational material was made available to the WAC on the subject of venereal diseases but not on contraception or prophylaxis. The incidence of venereal diseases was watched carefully, but it was so universally low that no great problem was presented.

SPECIFIC PROBLEMS OF FEMALE MILITARY PERSONNEL

Discipline

A frequent attitude in the Army was that "nothing could be done to Wacs who break rules." There was resentment among the men who felt that the "Wacs have all the good things of the Army: promotions, furloughs, assignments, but none of the restrictions." [34] Clear-cut policies of discipline were long delayed because of numerous complicated attitudes and situations. Some of the difficulties were related to the volunteer nature of the group, others were influenced by public-relation considerations, and still others to the inconsistent attitudes of company commanders, which varied from that of the overprotective mother to that of the hard-boiled woman policeman. These uncertainties, in themselves, "increased the number of disciplinary problems which ultimately were referred to the psychiatrist, not with the view of therapy but for elimination from the service." [35]

Court-martial.—Wacs were subject to court-martial proceedings with penalties identical to those for men. Legally, this was true, but practically, there were considerations which modified the sentences. Military courts, composed only of men, were uncertain of how to impose penalties because of lack of experience in dealing with infractions of regulations by women. Here, again, the inconsistency was apparent in the two extremes of either too great leniency or too severe harshness. The Director, WAC, therefore, attempted to introduce the WAC point of view by having a WAC officer on every court-martial in which women were being tried. This change was ineffective because the WAC officer was always junior in grade to the other members and could rarely exert much influence. Recommendations to have lawyers who were in the WAC selected expressly for service on courts-martial try WAC personnel were not approved.

Confinement.—The lack of suitable places of detention for Wacs raised many problems. No guardhouses were available. In civilian communities, the only places of confinement were civilian jails. In military installations where WAC contingents were stationed, the company barracks or cadre rooms had to be used for confinement. But this created resentment from

[34] Preston, *op. cit.*, p. 41.
[35] *Ibid.*

other occupants of the barracks, particularly if the personnel so confined belonged to some other WAC command. In the event of long-term imprisonment, the problem became still more complicated. In one situation observed by the author, a whole barracks room was given over to the detention of one Wac. The space for the offender was partitioned off by wire from the guards, a regular detail of three able-bodied military police. To alleviate her "sufferings," she communicated freely through the windows with visitors bearing gifts and sympathy.

Colonel Hobby's recommendation for the establishment of a disciplinary barracks at one of the training centers was disapproved by the War Department. The only recourse was to send female personnel who had been given long-term sentences to the Federal Industrial Reformatory for Women, at Alderson, W. Va. As described by Treadwell:[36]

> Cases accepted, however, were only those in which the individual had committed a felony or violated a civil law. Still undisposed of were sentences * * * that were imposed for violation of military regulations only.
>
> As the only alternative, a confidential letter was sent to all commands stating that, while courts would adjudge sentences as usual, the reviewing authority would direct discharge instead of confinement for Wacs who could not be transferred to Alderson and who did not appear to be useful members of the Corps.

Subsequently, all women's services adopted a similar policy with the explanation, in part, that it was presumed that if volunteers were no longer in a position to fill a military mission, they should be returned to civilian life.

Leadership

The problem of leadership[37] in the Army was of the highest importance, both for men and for women. Menninger[38] discussed leadership in some detail for men, but all he said on the subject was also applicable to women, as follows:

The effects of "good" or "bad" leadership were apparent so frequently in the Army as to drive home the simple fact that if a leader met the emotional needs of his men adequately they were greatly supported against personality disturbances. * * * If anything happened to his leader, he was particularly vulnerable to a psychological break.

Women were said to be more dependent on the company commander than were most men. A poor commander had an exaggerated effect upon women, and field commands noted that one of the Corps' most pressing needs was for good WAC detachment commanders; those sent out were frequently found to be deficient in their training, the experience, and the temperament for leadership.

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[36] Treadwell, *op. cit.*, pp. 506–507.

[37] The material in this section has been drawn from Treadwell, *op. cit.*, pp. 669–683, and unless otherwise indicated, quoted passages have been cited from this source.—M. D. C.

[38] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 73, 83.

Also, as was pointed out: "The strongest and most direct motivation is identification * * *. People gain emotional security by modeling themselves on a leader in whom they have confidence * * * attitudes, mannerisms, gestures, even voice tones are contagious."

Several studies on leadership indicated clearly that WAC commanders had to have positive qualities of leadership. The conclusions were: "The human values, and these values only, constituted the ability to lead women * * *—fairness, friendliness, unselfishness, sincerity, courage and a genuine concern for women." One of the training center commanders, Col. Frank U. McCoskrie, said: "You don't command women—you lead them."

The value of instruction in leadership came to be discounted except as emphasizing to women already possessing the necessary character qualifications, their importance and some techniques for their best utilization. It was recognized that leaders could not be made. Some of the problems of leadership in the WAC undoubtedly came from the general lack of experience of women in such a role. In this connection, Dr. Hildegarde Durfee, a psychologist, made the following pertinent comments in her study of the WAC officer:

> They [the WAC officers] are newcomers in a male setting; hence tend to feel on trial and under special pressure to make good * * *. Women as a whole have had less experience in group discipline and leadership. Theirs has been at once an over privileged and under privileged status in our society. They have been given more attention and consideration, but the price of this has been less opportunity and recognition.

She also commented that women tend to want to please and not to offend.

There was much evidence, however, which pointed to the existence of successful women leaders. Many surveys among enlisted women showed the stimulation of group loyalty by the commanders. "When not so inspired, a WAC unit seemed particularly liable to degenerate into feuding cliques and factions."

The effect of leadership on medical conditions was very apparent in the incidence of psychiatric disturbances, pregnancy, and sickness. In reference to the cause of widely different pregnancy rates among unmarried women at five units studied under similar conditions, Maj. (later Lt. Col.) Margaret Janeway, MC,[39] observed: "In those detachments where there has been continuous good leadership, the pregnancy rate has been low." As Menninger[40] said:

> There were countless recorded instances when the efficiency of a particular group was increased or decreased out of all proportion to the numerical strength by an unusually able or poor leader. * * * As he could gain satisfaction in a passive dependence upon his leader, the new soldier was able to give up his personal initiative, wishes, preferences and liberty to become submissive and obedient. These processes operated equally in the WAC.

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[39] Memorandum, Maj. Margaret Janeway, MC, for Col. Arden Freer, Surgeon General's Office, 27 Sept. 1944, subject: Visit to WAC Detachments at New York Port of Embarkation and Separation Center, Fort Dix, N.J.

[40] Menninger, *op. cit.*, pp. 83, 84.

Feminine Attitudes

The environment of the Army was modified to a great extent by the attitudes of the women themselves. In general, it may be said that, for women, military life tended to emphasize femininity rather than masculinity. So much of masculinity was forced upon them that the women overreacted in the opposite direction. Therefore, most of the differences peculiar to women as contrasted to men in military service were related to inherent or acquired feminine characteristics, or to unresolved internal bisexual conflicts.

Individuality.—One of the more marked differences was a tendency toward individuality rather than group activity. Regimentation and discipline were difficult for women because of previous experience and mode of life. Women working in the home are their own bosses, and even those working in offices are inclined to give only lip service to "the Boss."

Also, women are much more independent in matters of social conformity, particularly in regard to clothing. They conform to fashion trends, but each woman has to be different and exhibit her own interpretation of the styles, whereas a man is very "unhappy" if he varies from the uniformity of the group. Feminine modifications of the military uniform were further influenced by the desire for adornment, as demonstrated by corsages of flowers and pigtails tied with ribbons. The latter additions were more prevalent overseas when a longing for beauty in the midst of war was especially acute.

Personal habits.—Women placed much greater emphasis on keeping up personal appearances. Even under very adverse conditions, as in New Guinea where slacks were worn constantly, the women washed their clothes in cold water and ironed them meticulously, while the men wore theirs roughdried. Hairdressing, too, was a not to be forgotten ritual. It was a great morale factor both for the women themselves and for the men who saw them. Beauty parlors, at least as important as barbershops, were arranged with much ingenuity in the most unlikely situations. There was, for example, one in the middle of Burma, set up under a teakwood tree with only a bucket of cold water for equipment, but with an operator from "Charles of the Ritz," then temporarily a private in the "Engineers."

Another manifestation of femininity was the universal practice by women of decorating their living quarters. They were clever in finding local material, such as parachutes, for making bedcovers or curtains, and so-called "moonlight requisitions" were sources of supply for material to make furniture.

Eating habits also showed a feminine attitude. WAC messes with the regular Government-issue rations always had better cooked and more invitingly served food because the women demanded it. The palatability and attractiveness of food meant so much to them that sometimes they refused to eat adequately in combined messes where the esthetic element

was neglected. This attitude occasionally became pathological, resulting in loss of weight or severe anemia.

One great hardship for women was the lack of privacy in the Army. Throughout their lives, they were accustomed to regard this privilege highly. Living in a crowded dormitory and using a community shower room and latrine were somewhat traumatic experiences for many women. Overseas, this lack of privacy was a definite factor in increasing tension and in precipitating emotional disorders, especially after a period of a year or more.

Socialization.—The social life of women in the Army presented many complications peculiar to the service. Women of various strata were thrown together intimately in a way which is much less common to them than to men. Class differences are customarily maintained by women, and the necessity for them to break down these barriers, and to adapt to the leveling effect of the Army was usually difficult.

Their social contacts with men were abnormal because of rank distinctions. For example, nurses were frequently more congenial with the younger enlisted men than with the older and usually married medical officers, and WAC enlisted women might find appropriate contemporaries among male officers. But fraternizing between officers and enlisted personnel was against military regulations. This became a serious problem in isolated areas, where, with a scarcity of women, male officers attempted to usurp all available female companionship, regardless of rank.

The attitude of many men, both in and out of service, that all women in uniform were "on the make" was disturbing to the majority of women who were not so motivated. That the sex standards of many women did change while in the Army cannot be disputed, but this exemplified a wartime tendency not limited to military service but rather to a change in ethical standards facilitated by absence from the home community. Nevertheless, in the Army, there were definite restraints exercised by group opinion and lack of privacy.

TERMINATION PROBLEMS

In considering transition to civil life, this account will not extend much beyond January 1946, when the author left the Office of The Surgeon General. However, as Consultant to the Veterans' Administration for another 5 years, she became aware of some of the postwar problems of women veterans.

Discharge Policies

Timing for the discharge [41] of Wacs after the war terminated was a matter of considerable controversy among all concerned. Colonel Hobby

[41] Unless otherwise indicated, quoted paragraphs are from Treadwell, *op. cit.*, pp. 726–749.

expressed the opinion that the: "WAC should be disbanded as soon as possible after the war was over." However, the Special Planning Division of the War Department overruled this and stated that the only determining factor was "military necessity." The number of points required for discharge, which related to length of service and other factors, fluctuated for both the men and the women and was never adequately adjusted. This, probably, produced more dissatisfaction among the women than the men because, as volunteers, the women believed that they should be released now that the job was done. However, there appeared great pressure in most commands to retain the WAC contingents. The reluctance to effect their discharge was—

> generally related to the discovery that the need for skills common among female personnel had been underestimated, to an extent that raised doubts as to whether enlisted women could be allowed to leave at the same rate as enlisted men. Oversea theaters in particular had resolutely refused to face the fact that the WAC could never be entirely demobilized, as required by law, until male replacements were accepted for discharged Wacs.

The uncertain discharge policies were further complicated by the desire and planning of the Regular Army for inclusion of women. Maj. Gen. Willard S. Paul, Assistant Chief of Staff for Personnel, so stated before a Senate Committee in January 1946 and said: "The Women have done an outstanding job in this war." Even members of the WAC were themselves divided on the advisability of such as organization. One of the senior WAC officers said: "Peacetime Army life, as contrasted to emergency wartime service presented an unnatural situation for a woman." She pointed out especially the difficulties relative to establishing an adequate family life.

In spite of resistance on the WAC staff level, pressure on Congress increased for WAC inclusion in the Regular Army, which caused further vacillation in discharge policies and more uncertainty in the enlisted women. Finally in late 1946, General Paul called for volunteers among the WAC and permitted the release of all others.

In an attempt to convince Congress, Gen. Dwight D. Eisenhower, who initially had opposed the WAAC, reversed himself and said:

> In tasks for which they are particularly suited, Wacs are more valuable than men, and fewer of them are required to perform a given amount of work. * * * In the disciplinary field they were, throughout the war, a model for the Army. * * * More than this, their influence throughout the whole command was good * * * resulting in improved conduct on the part of all.

So in the attempt to be released from military duty, the Wac was somewhat belatedly showered with appreciation.

Separation Centers

Plans for separation centers for the various military components were

being formulated in early 1944. In a memorandum on the subject for the Deputy Director of Mobilization, Plans and Operations, ASF, the Consultant for Women's Health and Welfare [42] made recommendations which were only partially accepted. The recommendations, herewith included because the future problems which developed later were anticipated, were as follows:

a. That consideration be given to the utilization of the present WAC Training Centers at Fort Oglethorpe and Fort Des Moines * * *.

(1) Facilities for housing, mess, recreation, and hospitalization are available for large numbers without further expansion.

(2) The overhead administrative staff is familiar with the problems peculiar to women personnel.

(3) The medical staff would need minimum additions.

(a) The personnel is accustomed to type of examination required for women in military service.

(4) The women would be separated from the men personnel at a time when discipline may be lax.

(5) These centers would be available because new recruits would not be in training at that time.

(6) Any additional cost of transportation would be more than compensated for by the use of already existing facilities.

The separation centers finally selected were five in number, with Fort Des Moines added later. Except for Fort Des Moines, the facilities were inadequate in respect to numbers processed per day, from 3 to 35, the long periods of waiting, inadequate housing, and a loss of morale due to many other unsatisfactory conditions. As early as September 1944, Major Janeway [43] reported after a visit to the Separation Center at Camp Dix, N.J.:

Problems of discipline and morale have already arisen. The WAC officers do not have sufficient control over the itinerants, who mix with the enlisted women airing their complaints and spreading discontent among them. There have been occasions when the individuals separated had considerable of their mustering out pay stolen from them.

Because of many complaints, finally a War Department inspection team made a survey of the centers. Only Fort Des Moines received unqualified praise from this team.

A woman medical officer was assigned to each center in order to improve the procedure of the medical examinations. In most centers, very little counseling was given before discharge, and a minimum of preparation was made to help the Wac returning to civilian life.

Readjustment to Civilian Life

The Wacs had their own peculiar problems of readjustment (fig. 45). They soon found that they missed many of those intangibles which they had

[42] Memorandum, Maj. Margaret D. Craighill, MC, for Col. G. M. Powell, 5 July 1944, subject: Designation of Separation Centers for Separation of Female Personnel of the Army.

[43] See footnote 39, p. 467.

"It won't be much fun for us to be civilians again—we aren't supposed to have battle fatigue or neuroses."

FIGURE 45.—Cartoon, "Grin and Bear It." Reprinted by permission of Chicago Times, Inc.

learned to value in the Army, such as group comradeship and an interest in world affairs. They found themselves accorded little honor as veterans, and their military training was discounted by prospective employers. Even more than men, the women had become unsuited to the civilian environment because the change in their pattern of life had been more radical. They had become quite different persons from the women who enlisted 4 years before. Most of them had matured, had broader interests, and had developed a new and finer sense of values. These changes were not always understood or appreciated by their families and former associates. A study made for a thesis by a former WAC lieutenant pointed up some of the attitudes. Many of the symptoms noticed suggested strong depressive trends, such as "a lost feeling," "lack of initiative," "lack of

interest in former friends and environment," "nervousness and a feeling of strangeness," and "tiredness."

Those Wacs returning to civilian life who desired employment frequently found it difficult to obtain work. Some Wacs had learned new technical skills for which there was no demand in civil life, or the positions that were available had been filled through reemployment rights of the male veteran. In August 1946, a law was passed according the Wacs similar reemployment benefits, but by this time, the need for such rights was long past.

Upon return to civil life, some took advantage of their veteran's rights to obtain more education, some married, and others returned to former professions. Women veterans who had the most difficult time of adjusting were those who, because of military training and broader interests, desired to undertake new fields of endeavor. After considerable delay, some civilian groups, stimulated by the WAC's National Civilian Advisory Committee, did organize local committees to aid in these employment problems.

Hospitalization was made available in veterans' facilities for former Wacs. Soon after the war, a woman physician was appointed in each area to coordinate the medical policies for women under the jurisdiction of the consultant in the Veterans' Administration, who personally visited all Veterans' Administration hospitals in which there were facilities available or planned for women.

SUMMARY AND CONCLUSIONS

The use of women to "replace men" was a great experiment which was the object of much criticism and subject to many prejudices. From the mass of evidence, it appears to have more advantages than otherwise.

In this chapter, the disadvantages have been emphasized. Psychiatric conditions in the WAC were of more than usual importance, because they occurred in a conspicuous minority group. The actual number involved was small, probably about one-tenth of the Corps, compared to the magnitude of the problems created.

The volunteer status was responsible for many difficulties in its effect on the selection of recruits and the proper utilization of individuals, as well as on public opinion.

Women experienced unusual hardships from loss of individuality, unaccustomed group living, and regimentation with discipline. They profited, however, by gains in maturity, in adaptability, and in breadth of vision and interest.

With proper leadership, satisfactory assignment in a job, and a feeling of being needed, they performed with skill and enthusiasm. The use of women as staff directors was a help in bringing better understanding to higher commands of the special problems of the Corps. The women

company commanders served an important role in promoting group identification and solidarity.

The social situation with men brought out clearly the desirability of removing the "caste system" in a citizen's Army to permit off-duty association of personnel of opposite sexes, regardless of rank. Restrictions which are commonly observed in civilian employment would be applicable, such as the custom of supervisors not dating junior employees working directly under them.

Assignment of women for oversea duty would be more effective if given as a reward for good service. Better psychiatric screening, with limitation usually to those under the age of 36, would prevent many medical casualties. A limitation of 2-year tours of duty overseas would promote efficiency and return women who were still useful for service in the Zone of Interior.

The proper utilization of the Wac did not come until too late in the war to be appreciated fully.

CHAPTER XVI

Forensic Military Psychiatry

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HISTORICAL NOTE

Military law "is as ancient as war itself," [1] but in comparison, psychiatry's introduction into both military and civil courts is relatively new. Although Henricus Cornelius Agrippa (1486–1535) and his pupil Johann Wier (1515–88) [2] are credited as being the founders of the medical jurisprudence of insanity, many other enlightened persons have raised their voices since then in defense of the criminally insane, without much success.

In the United States, Isaac Ray has been acclaimed the father of psychiatric jurisprudence. In 1838, he published the first book in America on the subject "Medical Jurisprudence of Insanity" and devoted considerable effort in improving the lot of the criminally insane. Five years later, in England, the famous M'Naghten case led to the formulation of certain criteria, based on the M'Naghten rule,[3] which were eventually accepted in most States of the United States and were used in the Army during World War II.

MILITARY JURISDICTION

The sources of military jurisdiction include the specific provisions of the Constitution relating to such jurisdiction in the powers granted to Congress; international law; the Executive orders of the President; and in a provision of the fifth amendment. Military jurisdiction is exercised through military government, martial law, and military law by the following agencies: Military commissions, provost courts, courts-martial, courts of inquiry, and commanding officers exercising disciplinary powers under A.W. (Article of War) 104.[4] Although the psychiatrist could have been called upon by any of these agencies during World War II, his services

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[1] Branham, Vernon C., and Kutash, Samuel B. (editors): Encyclopedia of Criminology. New York: Philosophical Library, Inc., 1949, p. 249.

[2] Zilboorg, G.: Legal Aspects of Psychiatry. *In* One Hundred Years of American Psychiatry. Published for the American Psychiatric Assoc., by Columbia Univ. Press, New York, 1944, p. 509.

[3] The M'Naghten (or McNaughton) rule resulted from the trial of a man who attempted to shoot Sir Robert Peel and who killed his secretary, the defense attorney offering a plea of insanity. The court gave a ruling that the accused must have been unaware of the difference between right and wrong and that he must not have known the nature and quality of the act, if this plea were to be allowed. The ruling has been cited in many subsequent cases. *See* Harriman, Philip L.: The New Dictionary of Psychology. New York: Philosophical Library, Inc., 1947, p. 215.

[4] A Manual for Courts-Martial, U.S. Army. Washington: U.S. Government Printing Office, 1 Apr. 1928, p. 1.

and professional opinion were more frequently utilized in courts-martial and those administrative procedures requiring psychiatric evaluation. Of the three types of courts-martial, the psychiatrist did not, as a rule, become involved in the summary court-martial, the so-called company punishment, for minor offenses.

Military law.—The vast number of men and women who served in World War II were governed by the 121 Articles of War [5] existing at that time, for "one of the instruments for achieving and maintaining a high state of discipline is military law." [6] Nevertheless, many "civilian" soldiers became involved in offenses against military law. Why they were unable to make the necessary transition from civil to military status and accept the change in mores and law which now governed their way of life is illustrated by the following:

> In civil life, criminal law seeks to protect society from the depredations of its irresponsible members without prejudice to fundamental individual rights by hasty, ill-considered star chamber action. In military life, military law must not only attain these ends but must do more. The primary objective of the military services is to win wars, not just fight them. Therefore, military law must not only restrain individuals for the protection of military society, but must be an instrument which will assist in attaining the requirement that all members of the service march in a prescribed order. For this reason, certain acts which are considered inalienable rights in civil society are offenses in military society. For instance, the act of "telling off the boss." This is an inalienable right of the American civilian, but in the military service it may well constitute an offense punishable by courts-martial. In civil life, if a man does not like his job he can quit it. Such action in the military service would be desertion. Likewise, in civil life if a group of people decide they do not like working conditions and walk off jointly, that is a strike. In the military service, it is mutiny.[7]

PSYCHIATRIC EVALUATION OF THE ACCUSED

The 1928 "Manual for Courts-Martial" permitted investigation before, during, or after trial, if any reasonable grounds existed for the belief that the accused was, at the time of the offense or the trial, mentally defective, deranged, or abnormal. The commanding officer, exercising courts-martial jurisdiction, had the right to have the accused examined mentally and "no charge will ordinarily be referred to trial if he is satisfied that the accused is insane or was insane at the time of the offense charged." [8] The investigating officer also had authority to request such an examination before trial. In suspected insanity, the Manual [9] provided:

> An appointing authority may, in his discretion, suspend action on the charges pending the consideration of the report of one or more medical officers, or the report of a board convened under AR [Army Regulations] 600–500 [20 Nov. 1939; amended 7 Aug. 1942; 25 May 1944; 4 Feb. 1946] in a case where that regulation applies and it

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[5] A Manual for Courts-Martial, pp. 203–230.

[6] NAVPERS 10873, "Extracts From the Uniform Code of Military Justice," April 1951, p. v.

[7] *Ibid.*

[8] A Manual for Courts-Martial, p. 20.

[9] *Ibid.*, p. 26.

is practicable to convene such a board. The medical officers or board will be fully informed of the reasons for doubting the sanity of the accused and, in addition to other requirements, should ordinarily be required to include in the report a statement, in as non-technical language as practicable, of the mental condition of the accused both at the time of the offense and at the time of examination. The appointing authority may, in his discretion, attach the report to the charges if referred for trial or forwarded.

The court or any one of the personnel of the court, prosecution or defense, had the right to inquire "into the existing mental condition of the accused whenever at any time while the case is before the court it appears to the court for any reason that such inquiry ought to be made in the interest of justice." [10] In addition, after the trial—

The reviewing authority will take appropriate action where it appears from the record or otherwise that the accused may have been insane at the time of the commission of the offense, or insane at the time of trial, regardless whether any such question was raised at the trial or of how it was determined if raised.[11]

Criteria for Mental Responsibility

The criteria for mental responsibility used by the military services were originally derived from the M'Naghten rule,[12] and somewhat modified. This rule was traditionally called the right and wrong test. The 1928 "Manual for Courts-Martial" stated:

A person is not mentally responsible for an offense unless he was at the time so far free from mental defect, disease, or derangement as to be able concerning the particular acts charged both to distinguish right from wrong and to adhere to the right.[13]

Another determinant of mental responsibility was included in the Manual which established the requirement of "the accused's mental capacity either to understand the nature of the proceedings or intelligently to conduct or to cooperate in his defense." [14]

The criterion for mental responsibility, adopted by military law, was more liberal than the old "right and wrong test" because it also included the "adhere to the right," the so-called "irresistible impulse test." [15] It was, however, generally conceded that the irresistible impulse part of the test for mental responsibility was extremely limited in its applicability and, for practical purposes, could only be related to psychoses and severe neuroses. On occasion, the irresistible impulse was involved in certain

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[10] A Manual for Courts-Martial, p. 49.

[11] *Ibid.*, p. 74.

[12] See footnote 3, p. 475.

[13] A Manual for Courts-Martial, p. 63.

[14] *Ibid.*, p. 49.

[15] (1) Porter, W. C.: Military Forensic Psychiatry. *In* Manual of Military Psychiatry. Philadelphia: W. D. Saunders Co., 1944, p. 122. (2) War Department Technical Bulletin (TB MED) 201, 1 Oct. 1945.

neurotic compulsive disorders, such as kleptomania.[16] Thus, the "insane," properly equated with persons having psychiatric disorders, and persons with any type of mental illness, including a neurosis which could produce involuntary behavior, were properly protected according to the military laws of the time.

When, however, a person's mental capacity was affected by voluntary excessive use of alcohol or drugs, such an affected mental state could not be used as an excuse for a committed act. Nevertheless, if drunkenness or the effect of intemperate use of drugs was asscciated with the commission of an offense, the fact was admissible as evidence so that the court could give proper weight to such an association.

Provisions for Psychiatric Examination

In most instances, a single psychiatrist was requested to perform the psychiatric examination and report on the sanity of an accused. When the offense was of a more serious nature, a board composed of at least three officers was usually appointed by the commanding officer who had immediate jurisdiction over the particular court-martial involved. As the "Manual for Courts-Martial" stipulated, the request for such an examination could be initiated by the investigating officer, the trial counsel, the defense counsel, the court, or the commanding officer concerned. This board, appointed under the provisions of AR 600–500 (p. 476), had the specific function of inquiring into the mental status of any individual, prisoner or otherwise, of reporting its findings, and, where indicated, of making appropriate recommendations for disposition. Because of its function, the board was frequently referred to as a "sanity board." However, commanding officers of hospitals were authorized to appoint a board of medical officers under the provisions of AR 40–590, 2 February 1942, which board could be utilized by the hospital commander for any number of functions, only one of which was the mental examination of accused individuals before courts-martial.

In installations in the Zone of Interior where the personnel situation was stable, boards were appointed under both AR 600–500 and AR 40–590 in advance of their need and were convened when necessary. Usually, sufficient alternate members were appointed so that a full board could be called at any time.

Some of the service commands required psychiatric examination of

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[16] Although the term "irresistible impulse" was not specifically mentioned in the 1928 "Manual for Courts-Martial," it was implied by the possibility that the accused may intellectually distinguish what is right and what is wrong but may not be able to adhere to the right and refrain from doing wrong because of mental illness or defect, such as a compulsion neurosis. In this connection, the "policeman at the elbow test," or whether the accused had committed the crime in the presence of a policeman, was considered by many psychiatrists to be irrelevant and unscientific. Porter (footnote 15 (1)) mentioned irresistible impulse before July 1944, and TB MED 201, of 1 Oct. 1945, included it in the text. Early in the war period, the author who had had civilian court experience found it justifiable to introduce the irresistible impulse concept in certain appropriate cases.—R. J. B.

all offenders scheduled for general courts-martial. Others required such examination only when the question of mental responsibility arose. Variations in procedure for the determination of mental responsibility existed throughout the Army, not only in accordance with local policy but also in relation to the knowledge and experience of psychiatrists in civil and military law, to the availability of psychiatrists, to the time they could allot to individual cases, and to the lack of specific medicolegal information in the field. Although obviously necessary, the standardization of psychiatric military court procedure and the establishment of uniform rules were not accomplished until 1 October 1945, when TB MED 201 was issued. Col. A. E. Lipscomb, an attorney with the Judge Advocate's Division, and Lt. Col. Manfred S. Guttmacher, MC, of the Neuropsychiatry Consultants Division, in the Surgeon General's Office, had collaborated in the development of this technical bulletin. The bulletin contained information on the following topics:

1. Legal standard of mental accountability under military law.
2. Rules of evidence and methods of presenting testimony.
3. Relationship of types of psychiatric disorders to responsibility.
4. Value of punishment as a deterrent.
5. Suggestion for pretrial psychiatric examination of accused.
6. Persons who may be designated to carry out psychiatric examination.

Despite the late appearance of this bulletin, it was well appreciated and became the basis for further dissemination of forensic military psychiatry information in the postwar years.

Responsibilities of the Psychiatric Medical Officer

The responsibility of the psychiatrist in the evaluation of the accused was well summarized in TB MED 201, as follows:

> In order for a psychiatric medical officer to discharge efficiently his duties as a witness in courts-martial cases, he should thoroughly understand the legal standard of mental accountability enforced by military law and should be familiar with the proper methods of psychiatric examination and the basic requirements of expert testimony.

Examination

Upon referral of the accused for psychiatric evaluation, the examiner was supplied with as much pertinent information as was available. This included a statement of charges against the offender; information on the circumstances surrounding the offense; the basic reasons for questioning the mental responsibility of the accused; and statements concerning the offender's past and present behavior, his efficiency as a soldier, and any abnormalities of his behavior, including his habits as to the use of drugs

and alcohol. Injuries, such as head trauma, had to be reported or inquired into at the time of examination.

Before proceeding with the actual psychiatric examination, it was the duty of the examining officer to make clear to the accused not only his rights under A.W. 24 (self-incrimination) but also to explain the scope and purpose of the examination.

The subsequent examination had to be thorough not only in justice to the accused but also because the examiner had to be fully informed and adequately prepared to testify as an expert witness.

Testimony

As a witness, the examiner who testified in nontechnical language as much as possible was more favorably received by the court. In addition to the replies to the specific questions on mental responsibility required by the court, it was advisable to relate the circumstances of the conduct of the examination. When applicable, it was also advisable to include a simple explanatory evaluation of the results from procedures such as psychological testing, social histories from local and other sources, and pertinent laboratory and sobriety tests, and to explain how this information contributed to the total appraisal of the accused.

Impartiality on the part of the psychiatric examiner was most important. Regardless of whether the examination was requested by the defense, prosecution, or other interested party, the psychiatric examiner was, in essence, a physician who was presenting unbiased medical findings and opinions from a professional viewpoint. He was not qualified to express opinions on questions of law. On direct examination or cross-examination, he was obliged to answer the questions as they were presented and, as any other witness, could later explain and amplify what he meant. Since the members of the court were usually line officers with little or no knowledge of psychiatry, the psychiatrist was frequently asked by the court to explain part of his testimony or answer a hypothetical question for this purpose. Sometimes, as in the hypothetical question, when reply of the psychiatrist was intended to enlighten further or enlarge upon the testimony being presented to the court, it was included in the record of court procedure. In other instances, where only explanation of terms or psychiatric terminology was involved, the court could be temporarily "closed," and the statements of the psychiatric examiner were not included in the record. In either case, however, the psychiatric examiner's contributions to the court were more valuable when he was prepared to support such responses by personal knowledge and experience or by reference to the writings of authorities in books, treatises, or other publications.

Privileged communication.—Routine observations, or specially directed examinations, and the general medical care and treatment provided for military personnel were regarded as official acts. The information ac-

quired thereby was, therefore, not privileged, as explained in the Manual:

> While the ethics of the medical profession forbid them to divulge to unauthorized persons the information thus obtained and the statements thus made to them, such information and statements do not possess the character of privileged communications.[17]

Reports and depositions

Usually, an informal request was issued when a psychiatrist was required to testify before a court-martial. Occasionally, a formal subpoena was issued and served. Because of the usually large caseload and limited time, the psychiatrist often found it difficult to make such an appearance, especially if such requests were frequent. An understanding court could, in many instances, accept a deposition,[18] as authorized by A.W. 25, in lieu of personal testimony.

A deposition consisted of a complete report on the case, with answers to the required questions on mental responsibility. It also contained other information that might assist the court in understanding the pertinent medical and psychiatric aspects of the particular case. Although any authorized military officer or civilian could take and authenticate a deposition, it was usually either the defense or the trial counsel who appeared at the psychiatrist's office or clinic for this purpose. The thoroughness of the deposition, its individualization regarding the case in question by refraining from using a printed form, which was done in some installations, and the use of nontechnical language all contributed much toward satisfying the needs of the court. In addition, it saved the psychiatric medical officer from having to appear as a witness. On rare occasions, the psychiatrist was required to appear in court, despite his deposition.

When a board of medical officers was convened under the provisions of AR 600–500 or AR 40–590, the report of the board was formally submitted to the court or to the requesting authority. This report, in essence, was also a deposition. The submission of an adequate report frequently sufficed, although the court had the authority to request the appearance of any or all members of the board as witnesses.

When a certificate was used, the information included followed the same general format of the deposition or report of a board of medical officers. Written in certificate form, with the introductory statement "I certify" or "It is certified," such a certificate could also serve as a deposition. The certificate was usually brief. It was used more often in lesser offenses or where there was no question of doubt on the part of the examiner that the accused was mentally responsible. Here again, the individualized type of report was better received than one submitted on a prepared printed form.

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[17] A Manual for Courts-Martial, p. 130.

[18] *Ibid.*, p. 208.

Hospitalization for Purposes of Examination

Unit commanders or the provost marshal usually preferred to have the psychiatric examination of a prisoner performed on a hospital inpatient basis. They argued that transportation of the prisoner, back and forth from the hospital, for interviews, board meetings, or laboratory testing required the use of guards, which practice created hardships on a limited staff and multiplied security responsibilities. These arguments were, no doubt, legitimate in most cases, but by the same token, no hospital prison was more secure than the stockade, and prisoners in the hospital increased the workload of an already busy hospital staff. For these reasons, generally, the majority of prisoner examinations were performed on an outpatient basis, unless contraindicated by the presence of such illness which would ordinarily require hospitalization. This controversial issue has been presented here because of its frequent occurrence and because its amicable resolution depended upon the agreement reached by the referring agency and the psychiatric or general staff of the hospital. No specific rules or regulations were issued relative to a uniform procedure for this problem, for, probably, it was considered that the matter could best be handled by local policy.

PSYCHIATRIC RESPONSIBILITIES IN ADMINISTRATIVE PROCEDURES

Many persons were sent to the neuropsychiatrist for evaluation and treatment but, perhaps, a greater number were referred for examination and recommendation as to medical disposition and administrative discharge. (See chapter IX.) Such medical and administrative separations were of considerable concern to the psychiatrist because he could be called as a witness before a board of officers and because, not infrequently, line-of-duty determination and other administrative procedures were involved.

Medical Disposition

Under the provisions of section II, AR 615–360, and later, AR 615–361, issued on 4 November 1944, the neuropsychiatrist was frequently appointed as a member of the board of medical officers generally referred to as the "CDD (certificate of disability for discharge) Board." Even more frequently, however, he presented neuropsychiatric cases before this board which determined whether disposition would be accomplished by medical discharge. A major involvement of the psychiatrist with this board was the determination of the line of duty relative to disposition and commitment of psychotic patients. Those cases of psychosis whose line-of-duty status was determined to be "yes" after prior presentation before the "600–500 Board" (p. 476) offered little difficulty in disposition except

for a reasonable delay when transfer to a Veterans' Administration facility was necessary. Patients requiring continued psychiatric hospital care, whose illness was not considered to be incurred in line of duty, presented considerable difficulty in disposition, especially early in the war.

Commitment to St. Elizabeths Hospital.—Officers, nurses, or warrant officers with no war service, whose illness had developed in line of duty or during retirement, general prisoners, internees, prisoners of war, certain civilian employees under special contract, certain enlisted men, contract surgeons, and inmates of the Soldiers' Home could be committed to St. Elizabeths Hospital, Washington, D.C. This was accomplished upon recommendation of a board convened under the provisions of AR 600–505 (2 Aug. 1942). Such a board consisted of three officers, two of whom were required to be medical officers with one a psychiatrist, if practicable. This board only considered cases eligible for commitment to St. Elizabeths. As in the transfer of other patients to State and Veterans' Administration hospitals, committing patients to St. Elizabeths Hospital involved considerable time and effort.

Administrative Separations

Many chronic minor offenders, mental defectives, "alcoholics," psychopathic states including sexual deviates, and other personality disorders were referred for psychiatric evaluation but could be discharged from the service only by nonmedical (administrative) proceedings. These cases were usually first sent for psychiatric evaluation and then, if deemed appropriate, were referred to "Section VIII" boards. This section of the general regulations (AR 615–360, 26 Nov. 1942), dealing with premature separation from the service, provided for the release from active duty of a wide variety of behavioral problems under the heading "inaptness or undesirable habits or traits of character," as follows:

> (1) Is inapt [included mainly intellectual deficiency], or
>
> (2) Does not possess the required degree of adaptability for military service [included enuresis and personality disorders who manifested little or no acting out behavior] * * *, or
>
> (3) Gives evidence of habits or traits of character [included acting out behavioral disorders, alcoholism, and sexual perversions as homosexuality] * * * which serve to render his retention in the service undesirable * * * or,
>
> (4) Is disqualified for service, physically or in character, through his own misconduct [included mainly individuals injured and rendered disabled during the commission of a military or civilian offense], and cannot be rehabilitated so as to render useful service before the expiration of his term of service without detriment to the morale and efficiency of his organization * * *.

Although section VIII (AR 615–360, 26 Nov. 1942) provided for training, reassignment and reclassification, and rehabilitation for the inapt or inadaptable categories, in actual practice little salvage was accomplished, as indicated by the number of personnel discharged under these

provisions during World War II.[19] All cases were processed by a board of three officers, one of whom, if practicable, was a medical officer. Whenever practicable, a psychiatrist was called as a witness. But more often, the psychiatrist's report of his examination and findings was utilized in lieu of testimony. The board proceedings were governed by rules of procedure applicable in special courts-martial, and counsel was not authorized. The board findings and recommendations were reviewed by the convening authority (the next higher commander) and forwarded to a major commander, usually a general officer for final action and discharge, if indicated.

Discharge under the provisions of section VIII was generally of the honorable type for the inapt or inadaptable categories by reason of considering that "the conduct of the enlisted man during his current period of service had been such as would render his retention in the service desirable were it not for his inaptitude or lack of required adaptability for military service." In effect, such an individual was considered to possess defects of intelligence or personality which exculpated his inability to render adequate service. Not so for the other two categories that involved acting out or psychopathic behavior, chronic alcoholism, or sexual perversion, including homosexuality, for which discharge without honor (blue) was usually given.

In all cases whether honorable (white) or discharge without honor (blue), the reason for discharge as stated in the certificate of discharge was to be "Section VIII, 615–360; not eligible for reenlistment or induction." Thus, from the discharge certificate alone, no differentiation could be made for the cause of the premature release from service.

On 20 July 1944, section VIII (AR 615–360) was superseded by two new regulations as follows:

AR 615–369 provided for the separation of enlisted personnel who were "inapt" or did not possess the "required degree of adaptability" for service, or "* * * disqualified for service because of enuresis." An honorable (white) discharge was authorized.

AR 615–368 became the direct descendant of section VIII and dealt with "habits and traits of character" which serve to render retention in the service undesirable and those who were "disqualified physically or in character through misconduct." Individuals discharged under this regulation received a blue discharge, unless the reviewing authority determined that an honorable discharge was to be given under AR 615–369.

The next revision of AR 615–368, issued on 7 March 1945, provided, as previously, for the elimination of enlisted personnel with undesirable habits and traits of character as follows: "Psychopathic personality mani-

[19] Ginzberg gives figures for administrative separations from the Army (1942–45) as approximately 172,000 for inaptitude, inadaptibility, and undesirable habits and traits of character. This compares with 332,000 discharges for disability due to mental illness during the same time period. *See* Ginzberg, Eli, Anderson, James K., Ginsburg, Sol W., and Herma, John L.: The Ineffective Soldier: The Lost Divisions. New York: Columbia University Press, 1959, p. 61.

fested by antisocial or amoral trends, criminalism, chronic alcoholism, drug addiction, pathological lying or sexual misconduct in the service."

There was much dissatisfaction with these administrative discharge procedures, regardless of the need for such action. The psychiatrist was unhappy because of the considerable time required to evaluate the individual, to submit a certificate, and, when necessary, to appear as a witness. Unit commanders were unhappy because the officers comprising the "Section VIII" board were taken away from their primary mission of training. Also, many senior officers believed that administrative separation reflected adversely upon command and leadership ability. This belief was one of the major reasons why unit commanders attempted to use medical channels to rid themselves of soldiers who should have been administratively discharged. Other unit commanders believed that since the Medical Department, especially the psychiatrist, was so closely concerned, it should be a medical problem. Yet, in effect, the administrative procedure was an administrative problem and properly belonged in the domain of the unit commander.[20]

Line-of-Duty Determinations

Line-of-duty determination in sickness, injury, or death was usually made by the medical officer attending the patient. However, in accidental injury, a line officer was usually appointed, and a board of line officers determined the line of duty. When mental defect, alcoholism, drug intoxication, or self-inflicted injury[21] could or did result in illness, permanent disability, mutilation, or death, the psychiatrist was usually called to assist in making the LD (line-of-duty) determination.[22] A just and proper LD determination was important because of its immediate and future influence upon the person or his family.

Suicide.—The major issue in successful suicide was in the LD determination. In this connection, policy and guidelines were established as follows:

> Suicide is the deliberate and intentional destruction of his own life by a person of years of discretion and of sound mind. There is a presumption that a sane person will not commit suicide and this presumption prevails until overcome by convincing evidence. Evidence which merely establishes the possibility of suicide or raises a suspicion that death is due to suicide is not sufficient to overcome this presumption. However, suicide established by a preponderance of evidence sufficient to overcome the presumption

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[20] It is interesting to note that Army regulations dealing wtih the inadequate and character disorders have always carried the number "8," as in section VIII, AR 615–368, and currently AR 635–208. One can only speculate whether the use of the numeral 8 was intentional or purely coincidental.—A. J. G.

[21] AR 35–1440, 13 Nov. 1933 (revised 17 Nov. 1944), provided that the soldier would lose pay during absence for disease resulting from misconduct or due to intoxication from alcohol or drugs, and the disease was not in line of duty. A.W. 107 (Manual for Courts-Martial, 1928) also provided that loss of time from duty due to injury (and venereal disease) resulting from misconduct or due to intoxication from alcohol or drugs was bad time and had to be made up and that the injury was considered not in line of duty.

[22] (1) Army Regulations No. 40–1025, 12 Oct. 1940. (2) War Department Circular No. 458, 2 Dec. 1944.

is misconduct, and death by suicide of any sane person in the military service must be regarded as having occurred not in line of duty and as the result of his own misconduct.[23]

The question as to whether or not the subject, at the time of his act, was so mentally unsound as to be unable to realize the direct physical and moral consequence thereof, or, having such realization, to refrain from the act, is one of fact to be determined initially by the investigating officer in each case after thorough investigation and a consideration of all available evidence.[24]

Self-destruction created unique problems for the psychiatrist. The decision whether mental unsoundness existed at the time of self-destruction had to be made retrospectively as, in most instances, the deceased had not previously been seen or interviewed by the psychiatrist. The psychiatrist's responsibilities were more important, for the investigating officer and the LD board[25] placed considerable weight upon his opinions. The ultimate LD decision involved insurance payments, Government benefits to the dependent survivors, and the "honor" of the deceased and his family. Frequently, the psychiatrist found it necessary to conduct an investigation of his own, by interviewing witnesses, if any, and associates or acquaintances of the deceased, in order to arrive at an unbiased opinion and decision.

Sexual Offenders

Most sexual perversions, including homosexuality, were generally lumped together by both military and civil law into a group under the generic misnomer "sodomy."[26] Although psychiatry limited the term "sodomy" to specific types of homosexual acts, civil and military law also included bestiality, fellatio, pederasty, and necrophilia—all of which were considered to be felonies. Other sexual perversions, such as exhibitionism, voyeurism, fetishism, and transvestism, were considered to be misdemeanors and usually came under the purview of section VIII, AR 615–360. The perpetrators of such perversions were, however, also subject to courts-martial and other articles of war pertaining to conduct prejudicial to good order and discipline.

In sexual offense cases, the psychiatrist also found himself in the unenviable position of appearing as a witness. At such times, he was frequently asked to explain the nature of the sexual perversion involved. Sometimes, in justice to the offender, the psychiatrist found it necessary to volunteer such information either in his report or in his deposition, or by actual testimony. Some courts valued such explanations and acted accordingly; others found the explanations of the psychiatrist suspect and ignored his recommendations; and still others considered him "soft" and

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[23] Army Regulations No. 600–550, 24 Aug. 1943.

[24] *Ibid.*, 10 Nov. 1942.

[25] War Department Circular No. 226, 27 Oct. 1941.

[26] (1) A Manual of Courts-Martial, p. 177. (2) War Department Memorandum No. W615–4–42, 10 Jan. 1943.

overprotective of the culprit. Yet, most psychiatrists knew that, in some cases, the minor sexual offenses were but warnings of possible later felonies; that some sexual offenses were but symptoms of other psychiatric illness or neurosis; and that punishment rarely served as a deterrent or effected a cure.

Homosexuality.—Although many varieties of sexual deviation were observed in the Army, homosexuality was the most frequently encountered. Military codes of justice contain provision for the punishment of homosexual acts. As provided in the "Manual of Courts-Martial," an enlisted person in the military service charged with an overt homosexual act could be tried under the 93d Article of War for "sodomy" and, if convicted, could receive a maximum sentence of 5 years' imprisonment. Officers involved in homosexual acts were handled similarly, by either court-martial or administrative regulations dealing with the elimination of the noneffective officer. Discharges for homosexuality were usually without honor (blue). During and since World War II, however, there has been an increasing trend for homosexual offenders to be discharged from the Armed Forces under the provisions of administrative regulations. A more detailed discussion on the management of homosexuals is contained on pages 236–239.

Relatively few military personnel were discharged from the Army during World War II for homosexuality. Menninger[27] cited "some figures for 1943" in which "of 20,620 in the Army diagnosed as 'constitutional psychopaths,' 1,625 were presumably of the 'homosexual type'." However, he admits that these figures are probably of little importance as an indicator of either the true incidence or significance of the problem and states that "probably for every individual who was referred or came to the Medical Department there were 5 or 10 who were never detected." Credence can be given to this statement by the experience of many military psychiatrists. Perhaps the most convincing evidence in this respect was that of Fry and Rostow[28] who had made a survey of 183 men (former college students) known from detailed prewar studies to be homosexual. Of the 183, 51 were rejected at induction, only 29 for neuropsychiatric reasons. Only 14 were prematurely discharged from the service for various reasons. A total of 118 men who served from 1 to 5 years (58 percent as officers) with creditable records had concealed their homosexuality effectively.

The management and disposition of women homosexuals in the service was governed by the same rules and regulations that concerned men. The prevalence of homosexuality among women was not so extensive as many had predicted but presented some problems which are discussed in chapter XV, page 459.

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[27] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 225 and 227.

[28] Fry, C. C., and Rostow, E. G.: Interim Report OEM-cmr 337, 1 Apr. 1945, for National Research Council.

CRITIQUE

Forensic military psychiatry improved during the war and after. It compared favorably with the medicolegal processes in civil life, and the treatment and rehabilitation of prisoners in the Army far surpassed that of most States. Yet, military justice was criticized during and after the war. Some of these criticisms will be mentioned, although the psychiatric implications may appear remote.

The rapidity in which a military case was prepared as well as the speed in which trial was held has been subject to question. There have been arguments for and against such speed. Militarily speaking, war cannot wait for long legal procedures for the few involved; the witnesses and the court are subject to military orders so that expediency in preparation and actual trial is necessary to assure the presence of all pertinent persons. Moreover, the Army desires swift justice for morale and deterrent reasons, as well as for the avoidance of long delays for the accused. Thus, the thorough investigation before trial usually insured that there was sufficient evidence to warrant such procedure.

The criticism that the accused had already been considered guilty by the investigating officer before the individual came to trial was seldom valid. Many military courts-martial returned a verdict of "not guilty." Many civilian courts conduct similar pretrial hearings in order to limit busy dockets from trying cases where evidence is insufficient or the charges are so minor as to be handled by a lower or misdemeanor court. Similarly, many general courts-martial cases were remanded to a lower, special, or, even, summary court, by responsible unit commanders and investigating officers.

Since most trials involved enlisted men, their lack of representation on the court presented a legitimate basis for criticism.

Although the "Manual for Courts-Martial" stipulated the maximum punishments, it has been argued that such punishment has been unusually severe, sometimes, being influenced by convening or higher authority. This criticism may have been justified, particularly in units where discipline had been especially poor and where, it was believed, that setting an example would serve a desired purpose.

Another point of criticism was the court's use of the accused's previous criminal record. The psychiatrist and the sanity board, or any other board, in securing necessary information, were permitted to examine such records. Moreover, the psychiatrist was permitted to use this information to assist him in establishing a diagnosis or opinion. Further, if he appeared as a witness, he was also permitted to mention this earlier criminal record in support of his diagnostic conclusions. The court, however, was specifically enjoined from using such a record in adjudging innocence or guilt.

The military psychiatrist's position was that of an adviser to the court, regardless of how he was introduced into the case. He represented

neither the defense nor the prosecution, as is so frequent in civil cases. At times, it was difficult for the psychiatrist to maintain this neutral role because of personal feelings or because of influences exerted by the prejudices of either prosecutor or defense. The psychiatrist was only supposed to assist the court with relevant medical testimony or required professional opinions which were within his particular technical competence. As the psychiatrist became more knowledgeable in the military sphere, he increased his value to, and was accepted by, the various military courts and boards.

Changes in the Army trial system.—Because the war demonstrated some inequities and dissatisfactions in military justice and military trial system, the following changes were made after the end of the war:[29]

1. Enlisted men are permitted to serve on a court-martial, if requested by the accused soldier.

2. Officers may be tried by special courts-martial; formerly, they could only be tried by general courts-martial.

3. The accused can request legal representation at pretrial examination.

4. Lesser punishments than death and life imprisonment are authorized for crimes of murder and rape.

5. Coercion or unlawful influence in obtaining a confession, although forbidden in the past, has been made a criminal offense.

6. The innocence of the accused until he is conclusively proved guilty is stressed.

7. Disciplinary powers of commanding officers, as provided by A.W. 104,[30] have been expanded, and the limitations of these provisions have been made generally applicable to officers and enlisted men alike.

8. Convening authority can no longer influence the decision of a court-martial.

9. The law member of the court is required to be a qualified lawyer, and the utilization of the legal officer to decide questions of law has been established.

10. The members of a court-martial serve more as a jury, as in civil courts.

11. The appellate court of review now consists of experienced military legal specialists.

12. A separate Judge Advocate General's Corps has been established.

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[29] Many of these changes emanated as a result of the "Report of the Secretary of War's Board of Officer-Enlisted Man Relationships," 1947, often referred to as the Doolittle Board or Committee.

[30] The 15th Article of War in the 1951 edition of the "Manual of Courts-Martial."

CHAPTER XVII

Psychiatry in the Army Correctional System

Ivan C. Berlien, M.D.

GENERAL CONSIDERATIONS

The problems posed by the delinquencies of soldiers were out of all proportion to the numbers of prisoners who were confined as a result of conviction by courts-martial. The psychiatrist was more or less involved from the time an offense was committed until the offender was separated from the Army or was restored to duty. If any suspicion existed before or at the time of trial that the accused was mentally irresponsible, the defense, the trial judge advocate, or the court could have requested psychiatric examination. In fact, in some commands, it was a standing operating procedure to have every accused soldier examined by a psychiatrist before trial. Many who were found to be mentally ill were sent to hospitals rather than to trial by courts-martial. If convicted, the prisoner soon met a psychiatrist at the rehabilitation center, disciplinary barracks, or Federal penitentiary to which he was sent. The primary function of these institutions has always been the restoration of prisoners to duty as soldiers. The role of the psychiatrist in military prisons has been recognized and enlarged since World War I. Indeed, the psychiatrist has become a "key" figure in military correctional institutions.

ORGANIZATIONAL BACKGROUND

The authority to redesignate the U.S. Military Prison, Fort Leavenworth, Kans., to the U.S. Disciplinary Barracks, together with the statement of its mission, organization, and program, is contained in Sections 1451 to 1460 of Title X of the United States Code. With the exceptions of two sections, dealing with manufacture of supplies for the Army and donations to dishonorably discharged prisoners, these enactments became law on 4 March 1915 and governed the U.S. Disciplinary Barracks in World War II.

The U.S. Disciplinary Barracks at Fort Leavenworth was reestablished as a disciplinary barracks in November 1940, having been under lease to the Department of Justice for 10 years. Thus, with general mobilization, it was the only institution for general prisoners operated by the Army, the Atlantic Branch having been deactivated at about the same

time. (The Pacific Branch at Alcatraz, Calif., had been turned over to the Justice Department in June 1934 for use as a Federal penitentiary.) By V–J Day, there were in operation eight disciplinary barracks and five rehabilitation centers in the Zone of Interior. (This is in contrast to World War I, when there were only three disciplinary barracks and no rehabilitation centers.) Further, whereas, on 1 July 1918 (4½ months before the defeat of Germany in World War I), there were 3,996 prisoners in confinement in the continental United States, there were 23,062 general prisoners in confinement as of 1 July 1945 [1] (1½ months before the defeat of Japan in World War II).[2]

Before 9 September 1944, the responsibility for the supervision of the various phases of the program for military offenders was distributed among a number of War Department agencies. On 9 September 1944, following recommendations to the Under Secretary of War by Mr. Austin H. MacCormick, Civilian Consultant to the Secretary of War, ASF (Army Service Forces) Circular No. 296 was issued, activating the Correction Division in the Adjutant General's Office. The supervision and functions pertaining to military prisoners were centralized in that office.

On 29 April 1944, an officer of the Neuropsychiatry Consultants Division, SGO (Surgeon General's Office), established liaison with Col. Marion Rushton, AGD (Adjutant General's Department), then the administrative officer who was handling matters of clemency for the Under Secretary of War and who had been, for some time, actively engaged in work on the problem. Colonel Rushton became director of the Correction Division upon its activation and remained in that capacity, developing a broad and efficient program, until he left the service in February 1946. From the beginning of the liaison, the Neuropsychiatry Consultants Division acted in a consultative capacity to the Correction Division on matters pertaining to neuropsychiatry in connection with military prisoners.

PSYCHIATRIC SERVICES

In October 1942, nine cadres of five officers each, detailed by the service commands, were ordered to the U.S. Disciplinary Barracks, at Fort Leavenworth, for an intensive course in orientation in the operation of that institution (fig. 46). These cadres later returned to their respective service commands and set up "Service Command Detention and Rehabilitation Centers." (On 16 February 1943, the names were changed to "Rehabilitation Centers.") In each cadre, there was a neuropsychiatrist who received indoctrination in the methods employed by the Psychiatry and Sociology Board at Fort Leavenworth, which were then incorporated into each of the newly established centers.

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[1] A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 30.

[2] This comparison suffers because of the marked difference in military strengths in the two wars.—I. C. B.

FIGURE 46.—A psychiatric social work officer giving an orientation lecture on the functions of the neuropsychiatric service to new prisoners, U.S. Disciplinary Barracks.

Functions

The basic authority and directions for the establishment and functions of the Division of Psychiatry and Sociology in disciplinary barracks were contained in AR (Army Regulations) 600–395, issued on 30 January 1930. Subsequent revisions of these regulations did not change the provisions of paragraph 13 pertaining to the Psychiatry and Sociology Division. These provisions are as follows:

13. Division of psychiatry and sociology.—a. To be maintained.—There will be maintained at each United States disciplinary barracks a division of psychiatry and sociology.

b. Personnel; assignment. The commandant will make such assignment of personnel to this division as will assure its proper functioning.

c. Office in hospital. Office space will be provided in hospital buildings, if available.

d. Duties of medical officer in charge.

(1) The medical officer in charge of this division will—

(a) Maintain a permanent psychiatric and sociological register of each general prisoner and also, when directed by the commandant of each garrison prisoner.

(b) Advise the commandant in the selection of prisoners for assignment to disciplinary companies, restoration to duty, clemency, vocational training and guidance, schooling and parole (both home and local).

(c) Prepare extracts and summaries of psychiatric and sociological registers for boards requiring them.

(d) Maintain a library on penology and related subjects.

(e) Make such routine research and experimentation as may be feasible and also such special research and experimentation as may from time to time be ordered by higher authority.

(f) Collaborate with agencies conducting intelligence and allied tests of applicants for enlistment and give instruction in the detailed methods of conducting such tests.

(2) He will also be available—

(a) For membership on parole, clemency, or restoration boards, and, when detailed as recorder thereof, will be the custodian of the board's records.

(b) For such other duties, medical or otherwise, as may be found desirable, provided they are not inconsistent with the nature of his work at the institution.

To assist in the administration of the functions just outlined, a board of psychiatry and sociology was established, consisting of two line officers, usually the supervisor of prisoners and the parole officer, and the psychiatrist, or other member of the Psychiatry and Sociology Division, who acted as recorder and custodian of the board's records. The senior member present presided at meetings of the board.

The Division of Psychiatry and Sociology was staffed, in addition to one or more psychiatrists, by psychiatric social workers, clinical psychologists, and the clerical help required. The ratio of psychiatric social workers to psychologists to psychiatrists was generally 4 or 5 : 2 : 1 or 2. There generally was, during the war, at least one Red Cross field director who worked closely with the division, chiefly by obtaining a social history on each prisoner, through local Red Cross chapters.

In general, one social worker interviewed each prisoner within a few hours after his arrival at the institution during which time the basic data were obtained upon which to get a complete history; that is, addresses of school, family, past employers, and the like. Request for social history was immediately forwarded to the local Red Cross, and questionnaires were sent to family members, schools, police superintendents, and so forth, so that by the time the prisoner came up for his complete clinical workup, this collaborative and background material usually had been received and already filed in the prisoner's permanent register.

Individual Case Study

For the regular, intensive clinical case study, the prisoner was first interviewed at length by a psychiatric social worker who integrated the material obtained through questionnaires, as well as from the patient himself, into a complete social history. He was next interviewed by a clinical psychologist who performed a psychological examination, including intelligence tests, Army general classification tests, and projective tests when indicated. Both social worker and psychologist usually gave their estimates of the prisoner's personality, stability, and restorability. Then, the prisoner was finally interviewed and examined by the psychiatrist who

finally integrated all the findings into a complete report, together with diagnosis, if warranted by a disorder of sufficient severity, and recommendations to the commandant through the Psychiatry and Sociology Board relative to restoration and clemency.

Diagnoses, except in clear-cut cases, were not made. Rather, the behavior pattern of the prisoner was stressed, pointing out strong and weak parts of his personality. The final case reports were couched in nontechnical language, with an effort to make unequivocal statements. To be helpful to boards and commanding officers, the reports had to contain information and findings which could aid in answering the questions: "Is this prisoner restorable? Should he be granted clemency?" Obviously, a report in which there were inconsistencies between facts, opinions, and recommendations only served to confuse those correctional officers who had to work with the psychiatrists, especially those officers in higher headquarters who had no other knowledge concerning the prisoner and yet were responsible for, and made decisions relative to, restoration and clemency. Fortunately, such inconsistent reports were rare, and although some were better than others, by and large the individual case reports were of significant value. Obviously, the caseload per neuropsychiatrist in any par-

FIGURE 47.—The prison neuropsychiatrist and his assistant discuss one of the patients confined and under treatment at a U.S. disciplinary barracks.

ticular institution at any given time largely determined the worthwhileness of reports. In circumstances where the staff was adequate and the workload of the psychiatrist did not exceed two or three cases a day (fig. 47), reports could be considered maturely and made quite complete. On the other hand, with an excessive caseload, the psychiatrist's reports were prepared rather hurriedly and represented a quick appraisal rather than a carefully considered study.

One of the early errors of some psychiatrists was the frequent tendency to diagnose constitutional psychopathic state. Thus, at one rehabilitation center, in 1944, 74 percent of the prisoners had been classified as "psychopaths." Also, great discrepancies often existed between rehabilitation centers in the reported proportions of other diagnostic categories. One center reported 1.5 percent as mentally deficient, whereas another reported 15 percent so diagnosed. It would appear that the largest cause of errors was the lack of adequate criteria for psychiatric diagnosis. Perhaps next important was the error of placing too much emphasis upon cross-sectional findings, rather than considering the longitudinal pattern of the life history of the person concerned. However, following a recommendation made by Col. (later Brig. Gen.) William C. Menninger, MC, at the Under Secretary of War Conference on the Rehabilitation of Military Prisoners, Fort Leavenworth, 14–16 November 1944, emphasis was removed from the extensive use of diagnostic labels. Instead, stress was placed upon delineating accurate descriptions of personality patterns and, from these data, rendering a prognostic opinion. Even with this change in policy, an analysis of 2,520 cases studied in the month of December 1944 revealed rather wide differences in the frequency of diagnostic categories among the various Army correctional institutions. Thus, for instance, 76.4 percent of the general prisoners in Disciplinary Barracks "X" were diagnosed as constitutional psychopaths, whereas in Disciplinary Barracks "Y" only 12 percent of the prisoners were so diagnosed. Barracks "X" reported 0.6 percent of its prisoners as mentally deficient, compared with 15 percent of the prisoners so classified in Barracks "Y." Similarly, Rehabilitation Center "A" reported 0.5 of its prisoners as constitutional psychopaths, as contrasted with 58.3 percent of the prisoners so diagnosed in Rehabilitation Center "B." (See table 49 for a distribution of all general prisoners by neuropsychiatric diagnosis.)

RESTORATION TO DUTY

Psychiatry and Sociology Board

Generally, to expedite Psychiatry and Sociology Board hearings for the purpose of restoration, carbon copies of the individual case reports were sent to all members of the board before the meeting, in order to acquaint each member with the cases to be heard. At the hearing, the

prisoner concerned presented himself before the board and was interviewed by the members. At the conclusion of the hearing, the board made its recommendations for restoration. As previously indicated, the psychiatrist usually served as Recorder and Custodian of Records for the board. The report of the board, together with its recommendations, was forwarded to the commandant of the correctional facility, for approval or disapproval. In either case, the report was then forwarded to the War Department for final consideration.

Disciplinary Company

The first step toward restoration[3] to duty was to transfer the prisoner (later termed "trainee") to the disciplinary company (sometimes called "The Honor Company"). This transfer was usually ordered by the commandant upon recommendation by the Psychiatry and Sociology Board. For a time, commandants ordered the assignment of prisoners to the disciplinary company regardless of the Psychiatry and Sociology Board's recommendations. This, however, resulted in embarrassment when, later, the commandant's decisions were not approved by the War Department; for obvious reasons, therefore, this procedure was largely discontinued.

The reasons for assignment of prisoners to a disciplinary company by a commandant was understandable, for not being an experienced penologist, he would be guided by a prisoner's appearance, behavior and promises while in confinement, not realizing, for instance, that a forte of the "psychopath" is the making of a good impression in order to accelerate his release. Also, that a confirmed alcohol addict, after 2 or 3 months of abstinence, with regular exercise, good food, and training can often appear much like a "normal" man. An example was that of a prisoner with a long record of severe alcoholism and social and economic maladjustment being recommended by a line officer board president for restoration with the well-meant but trite and naive admonishment: "Now it isn't that you shouldn't drink—just don't drink too much."

In one rehabilitation center, such naive practices were slowly discouraged and almost entirely ended by the somewhat subtle method of maintaining, in the Psychiatry and Sociology Division, a "score board" of prisoners received for restoration, showing their subsequent records. As the number of failures of "psychopaths" and other unsuitable restorees mounted, the commandant showed more of a tendency to be guided by the recommendations of his Psychiatry and Sociology Board and less of a tendency to select men by a superficial impression gained after a brief interview. Of course, the never-ending informal educational campaign, conducted by the psychiatrists among their line officer confreres at the

[3] Sections 1456 and 1457 of Title X of the United States Code provide for military training and remission of unexecuted portions of the sentences of general prisoners considered suitable for honorable restoration to military service.

mess table, at board meetings, and in quarters, resulted in increased insight and broadened outlook on the part of the line officers and, as a consequence, enhanced prestige for the Psychiatry and Sociology Division.

Restoration process.—In general, all prisoners, found upon examination to be mentally and physically qualified for military service, whose civil and military records warranted consideration for restoration and who desired restoration, were assigned to the disciplinary company and were known as "probationers." Army Regulations No. 600–375, issued on 24 November 1942, provided that at any time after a probationer had served one-third of his sentence he could make written application for restoration. This requirement, however, was interpreted liberally beginning in the latter part of 1942 so as to give every prisoner considered suitable for restoration an opportunity to be returned to honorable duty, regardless of the portion of the sentence actually served.

Upon successful completion of the training program in the disciplinary company, the written application accompanied by a statement of the prisoner's civil and military record and statement of his mental and physical status, together with comments with regard to restoration, was forwarded to the Correction Division which acted for The Adjutant General. If the commandant's recommendation for restoration to duty was approved by the Correction Division, authorization was forwarded for the remission of the unexecuted portion of the prisoner's sentence and for his transfer to an appropriate service command for assignment to a military unit, based on his qualifications. Although these procedures were almost identical both in rehabilitation centers and in disciplinary barracks, the Commanding General, ASF, on 15 November 1943, directed that restoration to duty of all general prisoners from rehabilitation centers would be accomplished by suspension of the unexecuted portion of the sentence rather than by remission thereof. This action was motivated by the belief that a suspended sentence would provide a greater incentive to "make good" than if the sentence were completely remitted. Although this concept would seem valid, whether or not actual results of such a policy represented a significant improvement are not known.

Nonrestorables

Shortly after the establishment of the rehabilitation centers, these centers began receiving incorrigible and nonrestorable prisoners of all types, although such prisoners belonged, more appropriately, in disciplinary barracks or in Federal penal and correctional institutions. Reviewing authorities had limited screening facilities, which included little more information than was contained in the record of trial, to assist them in selecting the type of institution considered most suitable for each prisoner. Giving rehabilitation centers the additional function of a screening agency seemed to be the only practicable solution at the time. Therefore, in

November 1943, an ASF communication [4] stressed that rehabilitation centers screen out all prisoners not considered suitable for restoration, after a study of each prisoner's history and character, and transfer them to disciplinary barracks. This additional responsibility made necessary the addition of more psychologists, social workers, and psychiatrists, which personnel were already in critically short supply. The problem was solved, in part, at some rehabilitation centers by the utilization of trained enlisted and civilian personnel. By the end of the war (31 August 1945), 10,562 prisoners had been transferred from rehabilitation centers to various disciplinary barracks.[5]

However, by the spring of 1944, nonrestorable prisoners had accumulated in rehabilitation centers to such a marked extent that the psychiatry and sociology departments had developed serious backlogs in their psychiatric processing. In some instances, they were unable to interview and examine prisoners until 6 or 8 weeks after arrival. In an effort to alleviate this situation, the War Department, on 3 October 1944, issued Changes No. 7, AR 600–375, which charged reviewing authorities with the responsibility for screening all prisoners awaiting result of trial who might have serious psychiatric or neurological disorders in order not to send them to rehabilitation centers. In this connection, it is interesting to note that the Commanding General, Sixth Service Command, on 13 September 1943, wrote:

> The records of general and garrison prisoners received for confinement at the Sixth Service Command Rehabilitation Center, Fort Custer, Mich., since it was established in December 1942, show a large number of cases involving both mental and physical disability. Many others, while mentally responsible for their actions, are inapt and do not possess the required degree of adaptibility for the military service or give evidence of habits or traits of character which serve to render their retention in the service undesirable * * *. It is obvious that prisoners who are mentally or physically disqualified for service should not be sent to the Rehabilitation Center for the purpose of training them for further military service. Many of these prisoners should have been discharged and not brought to trial. Others, particularly garrison prisoners, might have been assigned to special training units for further military training.

On 6 June 1944, the Neuropsychiatry Consultant, Seventh Service Command, wrote: "* * * I would strongly recommend that a directive be issued from Washington to the effect that all soldiers to be tried by a general court-martial be examined by a qualified neuropsychiatrist prior to trial * * *." (Several commands did institute pretrial neuropsychiatric examinations.) However, it was decided that, for many reasons, the project was not feasible. Among such reasons was the fact that neuropsychiatric personnel in the Army were insufficient to meet the workload which would be created by such a change in regulations.

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[4] Letter, The Adjutant General, Headquarters, Army Service Forces, to Commanding Generals, First to Ninth Service Commands, 15 Nov. 1943, subject: Operation of Rehabilitation Centers.

[5] A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph, *op. cit.*, appendix XX, table 2.

MENTAL RESPONSIBILITY

Before and During Court-Martial

The provisions made in the 1928 Manual for Courts-Martial[6] for the protection of the accused in connection with insanity were fairly explicit. In the first place, paragraph 30c(3) provided: "No charge will ordinarily be referred for trial if he is satisfied that the accused is insane or was insane at the time of the offense charged."

According to paragraph 35c:

> An appointing authority may, in his discretion, suspend action on the charges pending consideration of the report of one or more medical officers, or the report of a board convened under AR 600–500 in a case where that regulation applies and it is practicable to convene such a board. The medical officers or board will be fully informed of the reasons for doubting the sanity of the accused and, in addition to other requirements, should ordinarily be required to include in the report a statement, in as nontechnical language as practicable, of the mental condition of the accused both at the time of the offense and at the time of the examination. The appointing authority may, in his discretion, attach the report to the charges if referred for trial or forwarded.

Paragraph 75a of the Manual further provided:

> If at any time before the court announces an acquittal or imposes a sentence it appears to the court for any reason that additional evidence with respect to the accused's mental responsibility for an offense charged should be obtained in the interest of justice, the court will call for such additional evidence. The court may adjourn pending action on a request made by it to proper authority that the accused be examined by one or more medical officers and that such officer or officers be made available as witnesses. * * * A request, suggestion, or motion that additional evidence be called for by the court as contemplated herein may be made by any one of the personnel of the court, prosecution, or defense. The court may, in its discretion, give priority to evidence on such issue and may determine as an interlocutory question whether or not the accused was mentally responsible at the time of the commission of the alleged offense. * * * If the court determines that the accused was not mentally responsible, it will forthwith enter a finding of not guilty as the proper specification. Such priority should be given where the evidence on the matters set forth in the specification is voluminous or expensive to obtain and has little or no bearing on the issue of mental responsibility for such matters.

Also, as provided in paragraph 63:

> The court will inquire into the existing mental condition of the accused whenever at any time while the case is before the court it appears to the court for any reason that such inquiry ought to be made in the interest of justice. Reasons for such action may include anything that would cause a reasonable man to question the accused's mental capacity either to understand the nature of the proceedings or intelligently to conduct or to cooperate in his defense. For instance, the actions and demeanor of the accused as observed by the court or the bare assertion from a reliable course that the accused is believed to be insane may be a sufficient reason. It should be remembered, however, that while a person who is insane to the extent indicated above should not be tried, nevertheless, until the contrary is shown, a person is presumed to be sane, and

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[6] A Manual for Courts-Martial, U.S. Army. Washington: U.S. Government Printing Office, 1928.

the mere assertion that a person is insane is not necessarily and of itself enough to impose any burden of inquiry on the court.

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If the court finds that the accused is insane, the proceedings so far as had embodying the finding to that effect will be forwarded to the reviewing authority; otherwise the trial proceeds.

After Court-Martial

In addition to all these safeguards before and during trial by court-martial, a prisoner still had ample opportunity after conviction and sentence to gain justice if it was shown, even at a later date, that he was mentally not responsible at the time of the commission of the offense of which he was convicted. If, in the case of a general prisoner, it was found that he was not mentally responsible at the time of the commission of the offense of which he was convicted, his sentence could be remitted and he could be separated from the service honorably by the provisions of section II, AR 615–360, of 26 November 1942.

After consultation with various psychiatrists who dealt with this problem constantly, it appeared that, actually, it was a rarity to find a prisoner who was not mentally responsible at the time of the commission of the offense of which he was convicted. In those few cases that were discovered where the prisoner was later determined to have been mentally irresponsible at the time of the commission of the offense, it was doubtful that a psychiatric examination before trial would have satisfactorily settled the issue. Analyses of these cases indicated that, in the incipient stages of mental disorder, there existed insufficient symptomatology or objective findings which would have satisfied the court that the accused "did not know the difference between right and wrong, and did not have the ability to adhere to the right." Within these criteria for mental responsibility, it appeared that the accused would have to be obviously "insane" in order to avoid trial by court-martial.

On 3 October 1944, Changes No. 7 to AR 600–375 read, in part, as follows:

* * * Whenever it appears to a reviewing authority that a prisoner awaiting result of trial may be suffering from serious mental or neurological disorder, he will, before designating the place of confinement, use all reasonably available facilities to determine whether such prisoner is suffering from any disorder listed in c(2)(d) * * * in order that prisoners suffering from such disorders will not be confined in a rehabilitation center.

The disorders listed were those which made restoration to duty unlikely for a soldier so afflicted. Although this change of the regulations was primarily intended to insure that nonrestorable prisoners would not be assigned to rehabilitation centers, it also provided, in essence, a post-trial examination which often resulted in a medical disposition rather than in affirmation of conviction.

CHANGES IN THE REHABILITATION PROCESS

Psychiatric Recommendations

On 16 November 1944, at the Under Secretary of War Conference on the Rehabilitation of Military Prisoners, Colonel Menninger, reporting on the group meeting of the psychiatrists of the conference, presented 12 suggestions, as follows:

Our first recommendation concerns the classification board. It is recommended that there be established an extension of functions and augmentations of the Psychiatry and Sociology Board or the creation of a classification board with chief function and purpose of planning and periodically reviewing the rehabilitation plan for each man. It is assumed that all members of this board would contribute to the prisoner program. The psychiatric contribution would include personality evaluation—perhaps more important suggestions regarding the rehabilitation of each offender. At the present time, and in some units, the psychiatrist's contribution is totally limited to psychiatric diagnosis and recommendations for disposition, whereas it is believed that his chief contribution should be advisory in planning and executing the rehabilitation program.

The second recommendation is relative to records. It is recommended that the standard P and S Board should maintain complete records on each man including both findings, claims, dispositions, recommendations, presumptions, accomplishments and that this record should accompany the prisoner if and when transferred to other corrective institutions.

The third recommendation has to do with nomenclature. It is agreed that diagnostic labels are often misused and more often misunderstood. Change 4 to AR 600–375 is too inflexible in the listing of diagnostic categories.

It is strongly recommended that consideration be given to some plan and necessary changes be made in existing directives and regulations which will eliminate the necessity of labeling each prisoner with a diagnostic term as such. In its stead the psychiatrist should furnish in simple and nontechnical language a concise, descriptive and dynamic formulation of psychoneurotic evaluations of the man including opinions as to salvageability, recommendations as to necessary security and suggestions relative to rehabilitation and disposition. Exceptions might include psychoses, mental deficiency, and neurological conditions. Further flexibility in the above-mentioned Army Regulation might be obtained if the board could rule that the soldier is not restorable at the present time with the implication that further training and rehabilitation would likely lead to restoration.

The fourth recommendation is on psychotherapy. On the basis of extensive clinical experience in psychoneurotic treatment methods, it is recommended that full utilization of group psychotherapy be developed in each rehabilitation center and disciplinary barracks by the psychiatrist or under his immediate supervision. Psychoneurotic experience indicates that it may be of definite benefit to the large percentage of the prisoners. Methods of presentation should be augmented by visual aids in the forms of charts, diagrams, movies, as well as simple propaganda techniques including printed material, newspapers, articles, etc.

The fifth recommendation is on clemency. It is recognized that certain specific types of psychoneurotic cases are special problems in the management of these individuals in rehabilitation centers and disciplinary barracks. This group includes the homosexual neurosis developed from combat, and men charged with misbehavior in front of the enemy, psychopaths with suicidal trends, epileptics with deterioration, the chronic alcoholics, the prepsychotic states, etc. It is recommended that a conference be held of a small number of the more experienced psychiatrists from these organiza-

tions for the purpose of developing recommendations and suggestions as to the best methods of management and disposition of these problem cases.

The sixth recommendation is followup system. On the basis of scientific experience we should know the degree of success and failure of our methods. This cannot be adequately judged merely on the basis of the number of men returned to duty or the status at the time of discharge from the disciplinary barracks or rehabilitation center. It is recommended that a followup system be developed whereby it might be possible to check our opinions and techniques in an individual case over a period of years as well as the results of our total efforts. Through such findings it might be possible to evaluate other procedures concerned with our work such as the methods of reassignment or of discharge and possible help to, and supervision of, the restored or discharged man. This latter responsibility should be recognized and used as part of our work.

The seventh recommendation is on neuropsychiatric personnel recognizing the importance of the psychiatric, psychological and the social contribution to the understanding of these problems. It is recommended that this group be implemented with adequate and trained personnel. Merely as a guide, the following suggestions are made on the basis of population of 1,500 and a turnover of 200 per month. We feel it should advisedly have 2 psychiatrists, 2 commissioned clinical psychologists, 10 enlisted men, 4 of whom at least should be psychiatric social workers in MOS 263 and 6 civilian stenographers.

The eighth recommendation is the selection and placement of personnel. On the basis that the proper selection and the placement of personnel working with the prisoners is of paramount importance, it is recommended that psychiatric and psychological help be requested relative to the selection and placement of such personnel. Furthermore it is suggested that certain basic requirements might be established for all guards including at least an eighth grade education, an AGCT score with a minimum of 85, a minimum age of 25 * * *.

The ninth recommendation is on a training program. It is believed essential that an organized training course covering this entire field should be presented to every member of the staff. Such a course should certainly include an outline of mental hygiene and psychiatry. It would appear possibly that three such courses might be necessary. First, a course for officers, to include perhaps 6 or 8 lectures in the field of mental hygiene or psychiatry. Second, courses for guards which we assume might have to run indefinitely for at least one hour a week. Third, a course for civilian employees.

The tenth recommendation is arrangements for the exchange of ideas and forms: It is recommended that for the psychiatrists and psychologists that machinery be established by which the forms developed in a particular unit might be available in exchange to the other units. This might be extended to include suggestions on experiences with various methods and techniques and very possibly the exchange of results.

The eleventh recommendation is provisions of a technical library: It is strongly recommended that a library dealing with criminology, penology, psychology and mental hygiene be established and be made readily available to all officers and enlisted men.

The twelfth and last recommendation—Prevention: It is recommended that a study be undertaken to determine whether our experience in these centers to date is capable of giving us some leads relative to the prevention of military offenses and the major problem concerned with the development and maintenance of morale in the Army.

Classification Board

In April 1945, the Correction Division suggested a procedure for classification in rehabilitation centers and disciplinary barracks which supplemented the recommendations offered by Colonel Menninger in that

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it recommended the extension of functions and the enlargement of the membership of the then existing psychiatry and clemency boards. This was made effective by ASF Circular No. 260, issued on 6 July 1945, which established a "Classification Board" and defined its duties, as follows:

3. *Interviews and investigations.* Study of each prisoner will include the following:

a.	Establishing the criminal history	thru	Interviewing, fingerprinting, and obtaining FBI and police reports
b.	Compiling the family and personal history	thru	Interview by social worker (sociologist), review of military records, correspondence with sources of information and Red Cross investigation (ordinarily will be provided by the division of psychiatry and sociology at a disciplinary barracks)
c.	Determining the physical history and health status	thru	Medical examination
d.	Determination of mental and emotional health, personality traits, intellectual level, academic achievement, and aptitudes and capabilities	thru	Psychiatric and psychological examination, educational and vocational testing
e.	Study of the religious background and the influence of religion in the prisoner's life	thru	Interview by chaplain
f.	Predicting the prisoner's apparent potentialities as a soldier and his adjustment as a prisoner	thru	Observations and report of commanding officer of reception company and other sources listed above

4. *Classification summary.* *a.* During the prisoner's last week in the reception company, a summary of the results of the study outlined above will be prepared by a classification officer for the use of the classification board on WD AGO Forms 95 and 95–1 (Classification Summary and Classification Summary Continuation Sheet). It will include all relevant and available data in concise form but will avoid repetition and irrelevant detail. Initial classification should not be delayed beyond 30 days. Data received following initial classification should be added to the summary prior to reclassification.

b. Automatic initial distribution of Forms 95 and 95–1 will be made to rehabilitation centers and disciplinary barracks during the period 15 July to 1 August 1945, after which additional supplies may be requisitioned in accordance with AR 310–200, as amended by WD Circular 264, 1944.

5. *Classification Board—Composition.* *a.* The Classification Board will consist of at least five officers appointed by the commandant. Its membership will represent both those who are responsible for examining and investigating the prisoner and those who are responsible for the supervision of major portions of the institutional program as they relate to the individual prisoner. In selecting the officers who are to be appointed to the Board, the commandant will exercise particular care to provide a balance between representatives of technical specialties (such as medicine, psychology, education, etc.) and officers with practical military experience. It is desirable that at least one member of the Board be an officer with troop experience, and one a member of the division of psychiatry and sociology. In addition to a classification officer as recorder, members of the Board may be chosen from among the following officers or their representatives:

Executive officer	Supervisor of education
Supervisor of prisoners	Chief medical officer
Company commanders	Psychiatrists
Training officers	Psychologist
Parole officer	Chaplain
Employment or vocational officer	Commanding officer of Reception Company
	Security officer

It is desirable that the president of the Board be a senior officer with general military experience.

b. If the institution has an exceptionally large turnover or if temporarily it has an unusually large backlog of cases, two or more boards may be organized. With two boards, it is desirable to arrange for occasional exchange of members, so that both boards will employ the same standards.

6. *Classification Board—Duties and responsibilities.* With respect to each new prisoner the Classification Board will make determinations regarding the following:

a. Restoration: If the prisoner is recognized as being definitely nonrestorable that entry should be made. Otherwise, a tentative recommendation with respect to restoration should be made. It is not usually advisable to attempt to determine finally the question of restoration to duty at the time of first classification and if there is any basis for doubt the decision should be deferred.

b. Clemency. The Board's recommendation with respect to clemency will be entered for the information of the commandant in making his recommendation in accordance with paragraph 18, AR 600–375, to the Adjutant General or the commanding general of the service command.

c. Custody. The custody believed proper for the prisoner will be stated in terms of one of the four following degrees of custody: A, B, C, or D.

Custody D means that the prisoner should be transferred to a maximum security disciplinary barracks, such as at Fort Leavenworth or Green Haven; in the event it is impossible to effect such transfer immediately, he should be held in the meantime in the most secure housing facilities available and be eligible only for assignments and activities which provide constant supervision and the closest guard.

Custody C means that the prisoner may be placed in the ordinary housing facilities of a medium security disciplinary barracks or of a rehabilitation center and that he is eligible for assignments under normal supervision within the enclosure but must be closely guarded if detailed to work outside the enclosure.

Custody B means that the prisoner may be assigned to live in the less secure housing units within the enclosure of a medium security disciplinary barracks or of a rehabilitation center and that he may go from one place to another within the enclosure under parole, but if detailed to work outside the enclosure he must be under at least nominal guard or the supervision of overseers.

Custody A means that the prisoner is sufficiently trustworthy to be permitted to live outside the stockade as in the case of honor companies, or their equivalent, or that he may work outside the main enclosure without guard.

Subcategories under A, B, C, or D may be distinguished as required by the special needs or facilities of the institutions. Length of sentence should not be the sole criterion of degree of custody; the latter should be based on all observations which have been made of the prisoner and all known circumstances of his case (of which length of time remaining to serve is only one). In recommending local paroles, the Board will consider the prisoner's custodial classification as defined above.

d. Transfer. The question of transfer to another place of confinement will be considered in relation to recommendations under *a* and *c* above. The degree of security provided by Army correctional institutions are to be considered in relation to the degrees of custody distinguished above. The disciplinary barracks at Fort Leaven-

worth and Green Haven are maximum security institutions. Prisoners at other institutions who are recommended for custody D by the Classification Board should be considered as candidates for transfer to Fort Leavenworth or Green Haven. The remaining disciplinary barracks and rehabilitation centers, which have been activated to date, are medium security institutions. Prisoners at Fort Leavenworth or Green Haven, and prisoners at rehabilitation centers not deemed restorable, who have been recommended for custody less than D, are to be considered as candidates for transfer to one of the medium security disciplinary barracks.

e. Work assignment. If it appears that the prisoner's rehabilitation will be facilitated by assignment to a particular vocation or that he possesses skills that are of special value to the institution, the Classification Board will make a definite assignment to such vocation or occupation. In all other cases, they will classify the prisoner for general work assignment, specifying such limitations to his assignment as may be required on the basis of his physical or mental condition and his custodial classification.

f. Special program. This includes assignment to school, recommendations for special medical, psychiatric, or other treatment, recommendations for family casework to be arranged through the Red Cross, and other special measures. The name of the social worker (sociologist) who interviewed the prisoner during the reception period will be entered here as the counselor responsible for following the progress of special treatment measures, unless other provision is made therefor.

g. Reclassification date. A definite date will be set in each case for review of the prisoner's program. When he appears before the Classification Board, he will be informed that subject to the approval of the commandant, he will be called up again for reclassification on the stated date. If it is believed that he will be eligible for local parole or some other change in status on the date specified, provided he has made a proper adjustment in the meantime, notation regarding this will be entered in the record and he will be advised of the same so that he may have a definite goal.

TRAINING OF CORRECTIONAL PERSONNEL

Most of the personnel, both officers and enlisted men, of the disciplinary barracks and rehabilitation centers were inexperienced in penology and criminology. They, as most military personnel, were subject to being relieved and reassigned, so that there was a rather rapid turnover of personnel. Attempts were made to stabilize correction installation personnel without success.[7]

To meet the needs for training, the Second Service Command Rehabilitation Center and Disciplinary Barracks developed an inservice training course for its guard battalion, based on a schedule of 5 hours each week for a year, a total of 250 hours. Of this time, 107 hours were devoted to orientation and basic penology, and 17 hours were allotted to classification, medical, psychiatric, psychological, and educational services. After completion of background lectures, given to the battalion as a whole, the men were divided into departmental groups, in accordance with the duties to which they were assigned. Each group received 63 hours of practical training in the specific duty performed. Included in these groups was one

[7] An excellent presentation of this phase is contained in chapter IV of "A Report of the Army's Program for Military Prisoners in the Continental United States During the Period September 1945 to December 1945." Historical Monograph (Vol. II) of the Correction Division, Adjutant General's Office, War Department, Washington, D.C.

assigned to the Classification Unit. This group was made up of two subgroups of which one was assigned to the Psychiatry and Sociology Division.

Hopeful that the personnel situation would soon be stabilized, plans for a central training center were carried forward, and on 16 August 1945, the Correction Department of the Adjutant General's School at Fort Oglethorpe, Ga., began its correctional custodial personnel course. Provisions were made for the training of 600 enlisted men at a time and for the training of 50 officers a month. Seven hours and four hours for enlisted men and officers, respectively, were allotted for psychiatry and classification lectures.

Thus, after 3 years of frustration in the matter of personnel, it was not until the end of the war that a central training program was authorized and underway. That psychiatry had become a vital part of the Army's correctional system was recognized by its inclusion in the basic training course for enlisted men and officers.

GROUP THERAPY

Early Development

As the war progressed and psychiatric personnel became increasingly scarce, it was not possible to assign a sufficient number of psychiatrists to correctional institutions to provide adequate diagnostic, classification, and therapeutic services. Because the classification process was a basic requirement, little of the psychiatrist's time was left for therapy. It was obvious that individual therapy could not be carried out, although, exceptionally, a likely prisoner would receive a few hours of treatment. It became increasingly evident that only by dealing with prisoners in groups could any therapy be accomplished.

Most correctional installations made some attempts toward meeting therapy needs by such means as lectures, discussion groups, or orientation programs. However, too often, these efforts were confined to the evening hours when, after a grueling day of hard labor or rigid military training, the prisoners were too tired to absorb even this meager orientation. Also, it was the rule that other events, such as movies and amateur night, took precedence and that the hour of group orientation would be canceled in favor of some other activity. A noteworthy exception was the Fifth Service Command Rehabilitation Center at Fort Knox, Ky. At this center, an excellent group therapy program was organized and in operation, in 1944. Its apparent success was due, in great measure, to the stimulation and enthusiasm in the effort which stemmed from the commandant and personnel consultant in charge of the program. The therapy was largely on a superficial level but served as an excellent mental catharsis for prisoners. Capt. Joseph Abrahams, MC, the psychiatrist, and Lt. Lloyd W. McCorkle (now one of the directors of the New Jersey prison system)

were particularly effective as group leaders or therapists. Under the system at Fort Knox, the men themselves carried on the discussions and were effective in calling each others' failings to the attention of the group, so that group pressure for social adjustment was effectively employed.

Formal Program Established

At the Conference of Rehabilitation Center Commanders, Omaha, Nebr., 20–21 June 1944, a representative [8] from the Neuropsychiatry Consultants Division, SGO, urged the commanders to adopt group therapy and to stimulate its use in all centers. The commandant of the Rehabilitation Center at Fort Knox also described, in glowing terms, the group therapy program conducted in his center and recommended its employment by all centers. However, MTP (Mobilization Troop Program) 22–1, which prescribed the military training program for rehabilitation centers, had not included provision for group therapy in the training schedule. Because of the interest and alertness of a member of the staff of the Military Training Division, ASF, who was present at the Omaha conference and who regularly inspected the training program in the various centers, this oversight was then remedied on 10 July 1944. Alert to the urgent need, and mindful of the success of group therapy at the Fort Knox Rehabilitation Center, the Military Training Division, ASF, included in its revised Mobilization Training Schedule, MTP 22–2, provisions for group therapy throughout the entire training period. This was the first time in the history of the War Department that the General Staff had agreed to the inclusion of group therapy as part of a training schedule for military personnel.

Colonel Menninger, later in 1944, at the Under Secretary of War Conference at Fort Leavenworth (p. 502), emphasized this modality of therapy, stating in part, as follows:

> If we are to regard these men in the light of psychiatry as being maladjusted, this implies the provision of the most important element in any readjustment process—insight. By the term insight, psychiatrists refer to an understanding on the part of the patient, that first, he is maladjusted (which many patients and certainly military offenders do not know), second, of the nature, and insofar as possible, the reasons for maladjustment, and third, of what his own contribution to readjustment must be. In the clinical practice of psychiatry, this is largely accomplished through individual interviews with the patient, called psychotherapy. Unfortunately, time and manpower prevent this from being possible in our rehabilitation centers, desirable as it may be. We do have ,however, the expedient substitute of group psychotherapy—the careful placement of men with similar problems in relatively small groups, with discussion and lecture by the psychiatrist. Group psychotherapy can be very helpful in giving the man a better understanding of his problem, but should not be confused with group "gripe" sessions, which, while possibly very valuable in moulding opinion, do not necessarily provide insight.

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[8] Berlien, I. C.: Rehabilitation Centers: Psychiatry and Group Therapy. J. Crim. Law and Criminol. 36: 249–255, November–December 1945.

Further Development

With these stimuli and its inclusion in the official training schedule, group therapy developed rapidly. At the close of the war, nearly every correctional institution in the Army was employing this method of therapy. Indeed, when one considers that, before the war, group therapy as such was either not employed at all in correctional institutions or at best only tolerated by those in authority, the forward strides made in the Army during the war are impressive to say the least. It is of interest to note that one of the first group therapy programs to be evolved in a civilian prison was that originated by a lay prisoner in the Auburn Prison, N. Y.[9] Although several State and Federal prisons had evolved "discussion groups" and group programs for selected types of prisoners (that is, constitutional psychopaths at Chillicothe, Ohio), it was not known whether group therapy, in the psychiatric sense, had been employed as an accepted or prescribed part of the rehabilitation program in civilian prisons.

Techniques

Techniques varied from one situation to another. The composition and size of groups varied, some being made up of prisoners with similar problems, as for instance, a group of illiterates. Some therapists worked with large groups and others with small ones. Some psychiatrists began their program with a lecture to a large group, followed by a discussion period. The large group was then divided into smaller components for which more frequent group therapy sessions were utilized. In general, experience in group therapy proved that better results and greater ease in management were obtained by using groups of not more than 30 to 35 (fig. 48).

As might have been expected, one difficulty encountered was that of the attempt at domination of the group by one or more "psychopaths." In fact, unless the therapist was unusually adept and exceptionally facile in his technique, it was found to be good practice to remove the more aggressive and resentful "psychopaths" from the general groups. The therapist could then place "psychopaths" together in a separate group, or could permit their inclusion in a group where there was some certainty of controlling the aggressions of the "psychopath" and of thwarting his efforts to dominate and occupy the center of the stage at all times.

Fort Knox program.—At Fort Knox, the group therapy program was divided into three phases; namely, the "preliminary," the "analytical," and the "synthetic." The preliminary phase occupied the first 9 weeks and was largely devoted to imparting a working understanding of psychological principles and their relation to behavior to the individual, to orient-

[9] Personal communication from Mr. Austin H. MacCormick, Director, Osborne Foundation, Civilian Consultant to the Secretary of War.

FIGURE 48.—A neuropsychiatric social work technician conducts a group therapy session, under supervision of the neuropsychiatrist, with U.S. disciplinary barracks prisoners.

ing him to the center, and to preparing him to consider his own problems. Among the topics presented and discussed in this phase were orientation talks, lectures with colored slides, "Human Personality" and "Personality Development," and methods of escape from reality.

The second, or analytical, phase lasted 12 weeks and attempted, through group discussion, to analyze the various group members' problems. Topics for discussion, from time to time, included AWOL (absent without leave) and desertion, the role of authority and the manner in which different personalities respond to authority, the personality defects of the "alcoholics," and the effects of fear on behavior.

The last, or synthetic, phase concluded the prisoners' last 5 weeks at the Center and aimed at having each group member analyze changes in his attitudes and underlying reasons for such changes, as well as helping him to rid himself of any remaining resentments or hostilities. During this last phase, the group also examined problems which were likely to arise following restoration to duty. Among topics discussed in this final phase were "profit by personal experience and experience of others," "adoption of patterns of expression which satisfy one and are acceptable in a social situation," and "adjustment to the new outfit."

Alcoholics Anonymous.—In connection with group therapy, another significant innovation occurred in correctional institutions during the war.

This was the participation of AA (Alcoholics Anonymous) in the rehabilitation program in several institutions. The alcoholic prisoner's participation in AA was on a voluntary basis. The AA program was conducted mainly in those institutions located in or near the larger cities. Civilian members of local AA groups regularly came to the rehabilitation centers and worked with those alcoholic prisoners who desired their help.

Trends.—As the war ended, several definite trends in group therapy were detected. There was a tendency on the part of most therapists to work with smaller groups (fig. 48) because of obvious factors. In larger groups, there was insufficient opportunity for everyone to talk, and the men were less likely to develop group identification. It was also noted that there was a growing tendency to select groups of men with similar personality patterns, difficulties, and needs. This followed the realization that prisoners profited most by participation in discussions of problems similar to their own and progressed more rapidly in gaining insight if all members of the group were concerned with similar difficulties than if the discussions centered on other or dissimilar problems. Thus, groups of neurotics with predominantly psychosomatic symptoms were organized, while other groups would be made up of schizoid or inadequate personality types.

Effectiveness.—Evaluation of the effectiveness of group therapy was difficult, particularly as it was only one aspect of the total rehabilitation program. Certainly, if enthusiasm of both prisoners and correctional personnel can serve as an index, it was successful. Many commandants, prison officers, guards, and others voluntarily stated that group therapy alleviated friction, disciplinary problems, and resentment. Because there was no possibility of experimentally using control groups, scientific evaluation was not accomplished. However, the widespread employment of group therapy and its inclusion in the official training schedule are facts which bear testimony to its acceptance and to the belief by both medical and line personnel that it was beneficial.

PSYCHIATRY AND CLEMENCY

Throughout the war and following the termination of hostilities, psychiatrists connected with correctional work shared in the responsibility of deciding matters pertaining to clemency (fig. 49). The psychiatrists in the various correctional institutions were required by AR 600–395 to make recommendations to the commandant concerning clemency. The Neuropsychiatry Consultants Division, SGO, received large numbers of these cases for review, opinion, and recommendations concerning clemency from the Clemency Branch of the Correction Division, and was also called upon by that division to take active part in determining official policies concerning clemency.

FIGURE 49.—A disciplinary and adjustment board meeting at a U.S. disciplinary barracks.

Criteria for Clemency

Those men found to be essentially normal and who met the physical requirements for duty were recommended for restoration to duty. This type of prisoner constituted no great problem. Even those prisoners who had some psychopathic traits, not of serious degree, were usually given the benefit of the doubt and likewise presented no serious problem. Many of the offenses involved were military in nature, without counterpart in civilian life. Indeed, most prisoners were convicted of AWOL, desertion, disobedience of orders, disrespect for officers or noncommissioned officers, or violation of arrest or confinement.

Prisoners who did not meet requirements for military service constituted the major difficulty to clemency, for many had mental or physical defects which rendered their retention as prisoners a strain on both facilities and personnel. In such cases, the psychiatrist was often tempted,

as were his line officer confreres, to recommend clemency on the grounds that continued confinement would avail nothing of value either to the man or to the service and might even aggravate the existing condition and make necessary transfer to a hospital.

Frequently, the psychiatrist recommended, and classification boards and the commandant approved, clemency for prisoners with neuropsychiatric disorders on the basis that continued confinement might result in their becoming psychotic. The problem which emerged was: "Is the prisoner's health the critical factor in determining clemency? Or should it be accepted, in the practice of penology, that offenders are not sent to prisons, disciplinary barracks, or rehabilitation centers for their health, and that it is presumed that confinement for violation of the law (Articles of War) is not conducive to improving one's mental well being?"

Morale factors.—In considering clemency for general prisoners, other factors also had to be considered. For instance, the effect upon troops of releasing prisoners while the war was raging had to be considered. To exert a deterrent effect, punishment for military offenses had to demonstrate to other soldiers that it was better to continue effective duty rather than to "mess up." To the man in a foxhole, risking his life hourly, day and night, in rain, in cold, or in jungle heat, "getting out" of the Army even by receiving a dishonorable discharge seemed like a reward for wrongdoing as compared to a daily fare of shells, bombs, mud, poor or no food, and danger—the apparent reward for which was more of the same hazards and hardships. An illustration of this morale factor was the case of a prisoner from the Mediterranean theater who was found to have a severe psychoneurosis with only a marginal adjustment. Because it was believed that continued confinement might result in more serious mental disease, clemency was granted and the man was dishonorably discharged. However, information found its way back to this soldier's combat outfit to the effect that he had been released from prison and was now earning "big money" in a war plant. The effect of this news on his former fellow soldiers' morale was definitely bad. Similarly, parents, relatives, and friends of combat soldiers demanded that military prisoners not be "pampered" or released to make high wages in civil life while "their boys," because they were "good soldiers," were risking their very lives and sanity at the "front."

It may be understood, therefore, that psychiatrists and others concerned with matters of clemency were confronted with problems which further produced conflicts within themselves.

Policies

The policies of the War Department concerning clemency were evolved after a great deal of consideration and consultation. The Neuropsychiatry Consultants Division played an important role in this connection.

Mental deficiency

From the psychiatric standpoint, it was believed that there were certain classes of prisoners to be considered. In March 1945, the policy of clemency for the mentally deficient was established. For this type of prisoner, the following were held to be the important factors:

1. Civilian background before military service:
   a. Social-economic history.
   b. Habits.
   c. Work record.
2. Military Record:
   a. Type of offense.
   b. Adjustment in confinement.
   c. Psychometric test results.
   d. Reason for maladjustment in Army.
   e. Attitude.

It was decided that the following conditions were to be satisfied before recommending clemency:

1. Clean or negligible civilian record of arrest or confinement.

TABLE 49.—*Distribution of the general prisoners in confinement at rehabilitation centers, disciplinary barracks, and Federal institutions, by neuropsychiatric diagnosis, 1945*

Diagnosis	Number	Percent
No diagnosis (essentially normal, no diagnostic label, no mental disease)	9,345	40.5
Diagnosis deferred	783	3.4
Constitutional psychopathy:		
Unclassified	5,495	23.8
Alcoholism	1,517	6.6
Drug addiction	124	.5
Inadequate personality	892	3.8
Emotional instability	721	3.1
Schizoid personality	184	.8
Recidivist	157	.7
Mental deficiency	1,570	6.8
Simple adult maladjustment	701	3.0
Psychoneurosis	449	1.9
Schizophrenia	81	.3
Other psychoses	25	.1
Epilepsy	21	.1
Other diagnoses	1,078	4.6
Total	23,143	100.0

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adiutant General's Office War Department, Washington, D.C., appendix XX, table 29 (modified).

TABLE 50.—*Distribution of 19,662 of 24,289 general prisoners, by place of confinement and principal military offense, 1945* [1]

Principal military offense	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Absent without leave	9,435	48.0	6,058	50.7	3,180	44.8	197	33.0
Desertion	5,690	28.9	3,549	29.7	1,961	27.6	180	30.1
Mutiny or sedition	119	.6	28	.2	45	.6	46	7.7
Misbehavior before the enemy	155	.8	31	.3	123	1.7	1	.2
Discreditable conduct toward superior officer	2,055	10.4	1,117	9.3	912	12.8	26	4.4
Misbehavior of sentinel	269	1.4	195	1.6	71	1.0	3	.5
Violation of arrest or confinement	1,625	8.3	846	7.1	687	9.7	92	15.4
Committing depredation or riot	103	.5	41	.3	59	.8	3	.5
Other	211	1.1	93	.8	69	1.0	49	8.2
Total	19,662	100.0	11,958	100.0	7,107	100.0	597	100.0

[1] Of the 24,289 prisoners for whom such reports were available, 4,627 were convicted of offenses of civil nature only.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 5 (modified).

TABLE 51.—*Distribution of 23,242 of 24,327 general prisoners, by place of confinement and educational attainment (grade completed), 1945* [1]

Educational attainment (grade completed)	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less than 4th grade	1,324	5.7	745	5.6	478	5.8	101	6.3
4th to 8th grade	12,493	53.7	7,085	53.1	4,542	54.7	866	54.1
1st to 2d year high school	5,506	23.7	3,257	24.4	1,895	22.8	354	22.1
3d to 4th year high school	3,439	14.8	2,046	15.3	1,168	14.1	225	14.1
Some college training	439	1.9	200	1.5	190	2.3	49	3.1
College graduate	41	.2	11	.1	25	.3	5	.3
Total	23,242	100.0	13,344	100.0	8,298	100.0	1,600	100.0

[1] Of the 1,085 unreported prisoners, 881 were in rehabilitation centers, 175 in disciplinary barracks, and 29 in Federal institutions.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 17 (modified).

2. No history of maladjustment due to alcoholism.
3. No history of nomadism.
4. Attachment to home and sense of responsibility toward it.
5. Reasonably good work record considering his intelligence level.
6. Not considered a problem in the community.
7. Not restorable to duty.
8. Good adjustment in the institution considering his intelligence.
9. Offense military or minor civil.
10. Psychometric tests and clinical observations indicate definite mental deficiency.
11. Inability to adjust in the Army because of or secondary to his mental deficiency.
12. Attitude good.
13. Reasonable assurance that the community will readily recognize his unfitness as a soldier and that he will assume a similar role in the community, home and on the job to that held before entering military service.

Psychosis

In deciding whether or not to recommend clemency for psychotic general prisoners, the following factors were considered:

1. Personality before becoming psychotic.—For instance, in the case of a constitutional "psychopath" with criminality, it was recommended that he not be granted clemency, but that he be transferred to St. Elizabeths Hospital, Washington, D.C., allowing his sentence to stand, because, should his sentence to confinement have been remitted and his transfer to a State or private hospital been effected, upon his recovery from psychosis

TABLE 52.—*Comparative percent distributions of the general prisoners and of enlisted men in the Army, by educational attainment (grades completed), 1944–45*

Educational attainment (grade completed)	General prisoners [1]	Enlisted men [2]
1st to 8th grade	59.4	28.6
9th to 12th grade	38.5	60.2
Some college training	1.9	8.2
College graduate	.2	3.0
Total	100.0	100.0

[1] Based on reports for 23,242 general prisoners in confinement during the year 1945 at rehabilitation centers, disciplinary barracks, and Federal institutions.

[2] Based on a 2-percent personnel survey as of 30 June 1944.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 28 (modified).

he would be discharged, thus allowing a criminal "psychopath" to return to society. On the other hand, in case the prisoner had a good record in civilian life and committed a military offense and was suffering an apparently chronic psychosis, clemency was recommended in order to permit his transfer to State or private hospital, if that were possible.

2. Nature of illness.—Early in the war, many recommendations for clemency were received in the War Department, for psychotic prisoners who, upon further investigation, were found to be exhibiting a "Ganser" or "prison" psychosis, from which they often spectacularly recovered when transferred to a general hospital, free from the prison atmosphere.

3. There was a tendency on the part of some psychiatrists, post surgeons, and commandants of disciplinary barracks to recommend clemency for "psychopaths" who simply exhibited temper tantrums, aggressiveness, and destructiveness and who, in general, were great nuisances. It was obvious that such recommendations represented a half-conscious, half-unconscious desire to "get rid" of them on the part of local authorities. A campaign of education resulted in markedly reducing such recommendations.

HOSPITALIZATION FOR PSYCHOTIC PRISONERS

Army Hospitals

At various times and at various places, the hospitalization of psychotic prisoners became a problem, complicated by the fact that, at times, various hospitals and rehabilitation centers were unsure as to which organization

TABLE 53.—*Comparative distributions of the general prisoners and of enlisted men in the Army by their scores on the Army General Classification Test, 1945*

Score	General prisoners [1]		Enlisted men [2]	
	Number	Percent	Number	Percent
130–162, superior	381	2.2	6,469	6.0
110–129, above average	2,630	15.1	33,089	31.0
90–109, average	5,276	30.2	33,320	31.2
60–89, below average	7,637	43.8	28,989	27.1
42–59, inferior	1,514	8.7	4,998	4.7
Total	17,438	100.0	106,865	100.0

[1] Based on reports of 17,438 of 24,327 general prisoners in confinement during the year 1945 at rehabilitation centers, disciplinary barracks, and Federal institutions.

[2] Based on a 1.54-percent personnel survey as of 31 March 1945.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 27 (modified).

should assume responsibility for clemency recommendations and as to the correct channels of command concerned. In the late summer and fall of 1944, there were so many psychotic prisoners at the Eastern Branch of the U.S. Disciplinary Barracks, Green Haven, N.Y., that a sizable number had to be transferred to Mason General Hospital, Brentwood, Long Island, N.Y. Careful investigation revealed that the great majority of these psychoses were psychosis with constitutional psychopathic state who

TABLE 54.—*Comparative distributions of the general prisoners and the mean strength of Army enlisted men, by age, 1944*

Age	General prisoners [1]		1944 mean strength of Army enlisted men [2]	
	Number	Percent	Number	Percent
Under 20 years	1,478	6.4	521,441	7.5
20 to 24 years:				
20 years	2,028	8.7	478,813	6.9
21 years	2,448	10.5	521,379	7.5
22 years	2,593	11.2	562,028	8.0
23 years	2,357	10.1	589,374	8.4
24 years	2,058	8.9	552,748	7.9
Total	11,484	49.4	2,704,342	38.7
25 to 29 years:				
25 years	1,900	8.2	535,671	7.6
26 years	1,541	6.6	479,308	6.9
27 years	1,201	5.2	389,472	5.6
28 years	937	4.0	334,408	4.8
29 years	843	3.6	283,860	4.1
Total	6,422	27.6	2,022,719	29.0
30 to 34 years	2,639	11.3	1,070,227	15.3
35 to 39 years	1,065	4.6	577,186	8.3
40 years and over	167	0.7	86,618	1.2
Grand total	23,255	100.0	6,982,533	100.0

[1] Based on reports for the general prisoners in confinement at rehabilitation centers, disciplinary barracks, and Federal institutions, in 1945. Age as of the time of sentence. (Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 25 (modified).)

[2] Percent distribution based on a sample tabulation, ATE–10· "Analysis of U.S. Army Personnel by Rank and Year of Birth as of 31 December 1944," Adjutant General's Office. These percentages were applied to the mean strength of Army enlisted men in 1944—for a numerical distribution by age.

Median Ages: General prisoners, 24.4 years; total Army enlisted men, 25.5 years.

TABLE 55.—*Distribution of the 21,867 of 24,327 general prisoners, by place of confinement and number of commitments, 1945* [1]

Number of commitments	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	15,287	69.9	9,138	72.3	5,112	67.1	1,037	64.8
One	3,671	16.8	1,988	15.7	1,372	18.0	311	19.4
Two	1,584	7.3	826	6.5	627	8.2	131	8.2
Three	697	3.2	372	2.9	266	3.5	59	3.7
Four	336	1.5	170	1.3	130	1.7	36	2.2
Five	125	.6	60	.5	55	.7	10	.6
Six	70	.3	36	.3	29	.4	5	.3
Seven	36	.2	23	.2	12	.2	1	.1
Eight	29	.1	15	.1	8	.1	6	.4
Nine or more	32	.1	20	.2	8	.1	4	.3
Total	21,867	100.0	12,648	100.0	7,619	100.0	1,600	100.0

[1] Of the 2,460 unreported prisoners, 1,577 were in rehabilitation centers, 854 in disciplinary barracks, and 29 in Federal institutions.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 22 (modified).

TABLE 56.—*Distribution of 21,376 of 24,327 general prisoners, by place of confinement and number of previous courts-martial, 1945* [1]

Courts-martial	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	6,642	31.1	3,732	29.1	2,071	29.7	839	52.9
One	5,012	23.4	3,122	24.4	1,534	22.0	356	22.4
Two	4,030	18.8	2,479	19.3	1,364	19.6	187	11.8
Three	2,689	12.6	1,669	13.0	920	13.2	100	6.3
Four	1,508	7.0	935	7.3	522	7.5	51	3.2
Five	850	4.0	519	4.0	296	4.2	35	2.2
Six	319	1.5	192	1.5	117	1.7	10	.6
Seven	167	.8	99	.8	59	.9	9	.6
Eight	84	.4	48	.4	36	.5	-------	0
Nine or more	75	.4	29	.2	46	.7	-------	0
Total	21,376	100.0	12,824	100.0	6,965	100.0	1,587	100.0

[1] Of the 2,951 unreported prisoners, 1,401 were in rehabilitation centers, 1,508 in disciplinary barracks, and 42 in Federal institutions.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 19 (modified).

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became violent and destructive in the Station Hospital at Green Haven, where the facilities were inadequate for their proper care. However, most of these prisoners improved rather well at Mason General Hospital, but became aggressive, often suicidal, at the suggestion of being returned to the Disciplinary Barracks to serve out their sentences. For these reasons, the Neuropsychiatry Consultants Division recommended that a small neuropsychiatric hospital be constructed at Green Haven in order to obviate transfer of psychotic prisoners to general hospitals and their subsequent severe reaction upon return to prison. Obviously, if such prisoners never left the Disciplinary Barracks, the issue of exacerbation of symptoms would not occur. However, for administrative reasons, this prison psychiatric hospital was never constructed.

Other Hospitals

Because the Federal Security Agency, according to AR 600–500,[10] may be designated by the Secretary of War to receive psychotic military prisoners, the possibility of their transfer to hospitals of that agency was explored early in 1945. However, St. Elizabeths Hospital was found to be the only institution to which such psychotic prisoners could be transferred because all other beds available to the Federal Security Agency were in hospitals of the Federal Bureau of Prisons. The Judge Advocate General of the U.S. Army ruled that it was not legal to transfer Army patients

TABLE 57.—*Distribution of 19,461 of 24,327 general prisoners, by place of confinement and general courts-martial, 1945* [1]

Courts-martial	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	17,989	92.4	11,599	94.8	4,985	88.3	1,405	89.4
One	1,320	6.8	602	4.9	577	10.2	141	8.9
Two	136	.7	39	.3	74	1.3	23	1.5
Three or more	16	.1	1	.0	12	.2	3	.2
Total	19,461	100.0	12,241	100.0	5,648	100.0	1,572	100.0

[1] Of the 4,866 unreported prisoners 1,984 were in rehabilitation centers, 2,825 in disciplinary barracks, and 57 in Federal institutions.

NOTE.—The entry .0 indicates a rate of more than zero but less than .05.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 20 (modified).

[10] Army Regulations No. 600–500, 20 Nov. 1939, with revisions of 7 Aug. 1942, 25 May 1944, and 4 Feb. 1946.

to any component of the Federal Bureau of Prisons unless a Federal prison had been specifically designated as the place of confinement in the court-martial sentence.

The question of transfer to a Veterans' Administration facility was likewise investigated. It was determined that the patient-prisoner or his legal representative would be obliged in each case to appeal to the Veterans' Administration for a ruling as to whether or not, in its opinion, the patient was or was not mentally responsible at the time of the commission of the offense of which he was convicted. If the Veterans' Administration ruled that he was not mentally responsible at the time of the offense, then the patient was entitled to care in its facilities, since a dishonorable discharge automatically canceled any benefits from the Federal Government.

Final Policy

On 29 October 1945, directions for the transfer, care, and disposition

TABLE 58.—*Distribution of the general prisoners, by place of confinement and crimes committed, 1945* [1]

Crimes	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Murder	6	0.2	3	0.2	-------	0.0	3	1.1
Rape	27	1.0	13	.9	10	.9	4	1.4
Robbery	259	9.4	148	10.6	97	9.1	14	5.0
Assault with intent to rob	20	.7	10	.7	8	.8	2	.7
Manslaughter	29	1.1	17	1.2	12	1.1	-------	0
Assault	27	1.0	15	1.1	8	.8	4	1.4
Burglary	618	22.6	302	21.7	250	23.5	66	23.6
Larceny and auto theft	1,127	41.2	572	41.1	433	40.6	122	43.6
Receiving stolen property	19	.7	6	.4	10	.9	3	1.1
Embezzlement and fraud	20	.7	12	.9	3	.3	5	1.8
Forgery	223	8.1	113	8.1	84	7.9	26	9.3
Violating liquor or drug laws	40	1.5	19	1.4	17	1.6	4	1.4
Other felonies	323	11.8	163	11.7	133	12.5	27	9.6
Total	2,738	100.0	1,393	100.0	1,065	100.0	280	100.0

[1] Of the 24,327 general prisoners for whom reports were available, 2,344 were known to have been convicted of crimes which resulted in commitments to penitentiaries or reformatories for adults, and of these, the crimes in 40 cases were not reported. The maximum number of crimes tabulated for any one prisoner was 2.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 24 (modified).

of psychotic general prisoners were promulgated in ASF Circular No. 405. Seven Army hospitals, chosen for various reasons among which was their proximity to correctional institutions, were designated to receive such patients. It was directed that such prisoners be carried as absent, or sick in hospital, by the prison installation designated as his place of confinement. Further, instructions were given for the disposition of those prisoners requiring prolonged care. It was directed that recovered patients would be returned to their proper places of confinement.

STATISTICAL DATA

Various statistical data on Army general prisoners confined during 1945, pertaining to psychiatric diagnoses, type of crime committed, demographic information, and previous offenses are presented in the tables (49–59) throughout this chapter.

TABLE 59.—*Distribution of 21,039 of 24,327 general prisoners, by place of confinement and number of arrests in civilian life, 1945* [1]

Number of arrests	All institutions		Rehabilitation centers		Disciplinary barracks		Federal institutions	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
None	8,720	41.4	5,418	42.8	2,601	38.3	701	44.3
One	2,575	12.2	2,145	16.9	140	2.1	290	18.3
Two	2,772	13.2	1,568	12.4	1,006	14.8	198	12.5
Three	2,042	9.7	1,010	8.0	879	12.9	153	9.7
Four	1,380	6.5	697	5.5	598	8.8	85	5.4
Five	984	4.7	516	4.1	417	6.1	51	3.2
Six	627	3.0	330	2.6	266	4.0	31	1.9
Seven	399	1.9	190	1.5	186	2.7	23	1.5
Eight	329	1.6	170	1.3	146	2.1	13	.8
Nine or more	1,211	5.8	617	4.9	556	8.2	38	2.4
Total	21,039	100.0	12,661	100.0	6,795	100.0	1,583	100.0

[1] Of the 3,288 unreported prisoners, 1,564 were in rehabilitation centers, 1,678 in disciplinary barracks, and 46 in Federal institutions.

Source: A Report of the Army's Program for Military Prisoners in the Continental United States During the Period November 1940 to August 1945. Historical Monograph of the Correction Division, Adjutant General's Office, War Department, Washington, D.C., appendix XX, table 21 (modified).

CHAPTER XVIII

Neurology

William H. Everts, M.D.

COORDINATION OF NEUROLOGY ACTIVITIES

Neurology and psychiatry in the Army had always been coordinated within the single administrative purview of neuropsychiatry.[1] Neurology, along with psychiatry, was thus the responsibility of neuropsychiatrists either directly or in a consultatory manner. Since psychiatry was by far the heavier part of the workload, neurologists were submerged by the mass of psychiatric cases. However, wherever competently trained neurologists were stationed—and there was a marked paucity of such officers—they performed most creditably in this dual role. In general, however, many psychiatrists lacked adequate neurological training, and many neurologists lacked adequate psychiatric training. As the ever-increasing volume of neurological problems became manifest during 1942 and 1943, it became imperative that better coordination of neurology and psychiatry be facilitated. To attain this end, a neurologist was assigned to the Neuropsychiatry Branch in the SGO (Surgeon General's Office), in October 1943.

When the Neuropsychiatry Branch was elevated to a division, on 1 January 1944, Neurology was designated as one of its branches, with Maj. (later Lt. Col.) William H. Everts, MC, as its chief. Later, in conformity with directions from The Surgeon General that officers not having had oversea service be given the opportunity for such service, Major Everts was relieved, on 2 July 1945, by Maj. Alexander T. Ross, MC, who had returned from the European theater.

In broad outline, the duties of the Neurology Branch were to coordinate the practice of neurology in the Army, to set policies for diagnosis and treatment, to procure personnel and equipment necessary to maintain high standards, to prepare neurological memorandums and technical bulletins, to collect and collate material of neurological significance, to stimulate research, and to effect a constructive, collaborative liaison with neurosurgery as it pertained to neurology.

In order to develop these policies in the most effectual fashion, it was considered advisable to enlist the services of two outstanding civilian

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[1] Thanks are due to Drs. James L. O'Leary and Alexander T. Ross whose contributions have been incorporated in this chapter.—W. H. E.

neurologists as consultants. Accordingly, on 10 May 1944, Dr. Edwin Zabriskie was appointed Consultant in Neurology, and on 24 June 1944, Dr. Frederick A. Gibbs was appointed Consultant in Neurology to advise especially in electroencephalography. These civilian consultants in neurology and their counterparts in psychiatry, Drs. Edward A. Strecker, Arthur H. Ruggles, Frederick W. Parsons, and Alan Gregg, all gave advice, time, and effort, unstintingly. They were called in consultation on frequent occasions and aided in the formulation of policies, some of which later appeared in technical medical bulletins and pertinent Army regulations.

DISQUALIFICATION FOR NEUROLOGICAL REASONS

The neurological standards for acceptability into the military service that governed during World War II were those published in MR (Mobilization Regulations) 1–9.[2] In essence, the methods of routine neurological examination and the criteria of acceptability and rejection for military service are outlined and formulated in these regulations.

It has been estimated that, as of August 1945, some 277,300 selective service registrants were classified as IV–F (unfit for military service) for neurological disorders, on the basis of these neurological standards. These disqualifications constituted 5.7 percent of all disqualifications. Expressing it differently, some 1.7 percent of the examined registrants in World War II were disqualified for neurological reasons. (See appendix A, table 5, columns 3 and 4, and table 7.) World War II disqualification data for neurological disorders indicate that most of these disqualifications were for residuals of cerebral or spinal concussion (35.7 percent of the neurological disqualifications) and next was epilepsy (23.1 percent). About 7.0 percent of these disqualifications were for peripheral nerve diseases, and the remainder (34.2 percent) consisted of miscellaneous neurological disorders. (These data are limited to those specifically listed under the neurological diagnostic category, excluding such nonspecific neurological defects as neurosyphilis, et cetera.)

Compared with World War I experience, it seems that at least twice as many were disqualified in World War II for neurological defects. (See appendix A, table 7, last column.)

ORGANIZATION IN ZONE OF INTERIOR

Neurological Centers

With the anticipation of D-day in the European theater and with the increasing activity in other theaters, it was urgent that medical facilities be established to cope with expected neurological-neurosurgical casualties.

In World War I, relatively few cases needing definitive neurosurgical

[2] Mobilization Regulations No. 1–9, 31 Aug. 1940, and 15 Mar. 1942. (See appendix B, pp. 777–791.)

care arrived from overseas, most having already been operated upon and with their status being changed from surgical to neurological patients. As a consequence, patients were admitted to geographically separated general hospitals and received treatment on general surgical services to which were assigned such neurosurgeons and neurologists as were available. This was not altogether a satisfactory clinical arrangement from the standpoint of adequately utilizing the specialties of neurology and psychiatry. With knowledge of this past experience, it was deemed advisable to keep neurology separate from neurosurgery and yet effect a close liaison between them. Since 19 strategically located hospitals specializing in neurosurgery had already been established,[3] it was obvious that maximum efficiency and closest collaboration would be obtained by designating these same hospitals as specializing in neurology. This was effected by WD (War Department) Circular No. 347, issued on 25 August 1944, which designated the centers and indicated the types of patients to be referred into them. Initially, each center had an authorized capacity of 200 neurological beds, although this could and did vary as the need arose with some sections carrying, at times, over 400 neurological patients.

In order to utilize the full advantages of specialized hospitals located as close as possible to the patients' locality of preference, to save transportation facilities, and to maintain high morale, ASF (Army Service Forces) Circular No. 284, issued on 30 August 1944, directed that patients arriving at debarkation hospitals from overseas be promptly reported by code to the Medical Regulating Office. For neurological disorders, the symbol was "SF" and included the following types of cases:

(1) Epilepsy of any cause.
(2) Encephalopathies.
(3) Encephalitis or meningitis residuals or complications.
(4) Disseminated sclerosis.
(5) Inflammatory disorders such as encephalomyelitis, myeloradiculitis, Guillain-Barré syndrome, etc.
(6) Migraine.
(7) Myelopathies of degenerative vascular and traumatic causes (exclusive of obvious spinal fracture cases).
(8) Neuritis and polyneuritis of any cause.
(9) Muscular dystrophies and atrophies.
(10) "Ill-defined" disorders affecting the central or peripheral nervous system.

To these later were added closed head injuries and sciatica (ASF Circular No. 89, 10 March 1945).

Relationship with neurosurgery

The organization of centers proved to be most effective for the definitive care of neurosurgical disorders, facilitating an optimal working relationship with neurosurgery so that there was minimal duplication of

[3] War Department Circular No. 235, 12 June 1944.

diagnostic effort. Further, the previously common confusion of admitting nonsurgical patients to surgical wards was avoided. In this manner, the neurological sections became the primary diagnostic units of the centers so that more and more of the surgeon's time could be spent on strictly surgical activities. This was of no little importance since, as the war increased in tempo, the surgical load became increasingly great and taxed all neurosurgical personnel and facilities to the utmost.

The collaboration between neurosurgeon and neurologist was thus a natural one. The neurologist assumed a much greater role in screening all patients with disease or trauma of the nervous system and in carrying out all basic neurological studies short of surgery. The desirability of making this a uniform procedure throughout all the hospitals specializing in neurology and neurosurgery was recognized by The Surgeon General. Accordingly, the Surgeon General's Office, in a letter of 28 January 1945, brought this matter to the attention of each service command surgeon, the professional consultants, and the commanding officer of each center. In this letter, also, was stated that total authorized beds for neurosurgery would be increased from 9,250 on 29 December 1944 to 21,887 on 16 January 1945 and that two new centers would be established by transfer. The center at Walter Reed General Hospital, Washington, D.C., was ordered moved to Halloran General Hospital, Staten Island, N.Y., and the one at Brooke General Hospital, Fort Sam Houston, Tex., to McGuire General Hospital, Richmond, Va. Objection was raised to the assignment of a neurologist to each neurosurgical ward, and consequently, a followup letter dated 14 February 1945 clarified the issue by stating: "A review of the total available number of neurologists discloses that there is an insufficiency to permit the assignment of a neurologist to neurosurgical wards. Neurologists are to be regarded as consultants to surgery and not assigned to that section."

This then was the final organization of neurology which proved most effective and capable of coping with any caseload anticipated from the European and Pacific theaters, the latter at the time having taken on increased intensity and proportions.

The establishment of these neurological centers did not preclude study and treatment of neurological patients in regional and general hospitals where competently trained personnel and proper equipment were available. However, where specialized attention, prolonged observation, or definitive treatment were entailed, these patients were transferred to the nearest neurological center.

In order to increase uniformity in neurological procedures, War Department Technical Bulletin (TB MED) 76 was prepared and issued on 28 July 1944. Also, a new neurological form (WD, AGO Form 8–49, 1 August 1944) was provided which made possible orderly reporting and also served as a guide to less experienced medical officers.

Location

The general hospitals at which neurological centers were established during World War II, together with the medical officers who served as chiefs of the neurology sections or as neurologists, are as follows:

	Number of beds	*Medical officer*
First Service Command:		
Cushing	125	Maj. (later Lt. Col.) Frederic H. Lewey
Second Service Command:		
England (Thomas M. England after 14 Nov. 1944)	300	Capt. (later Maj.) Robert L. Craig
Hollaran	200	Maj. Waldemar C. Rasmussen
Third Service Command:		
McGuire	200	Capt. Philip K. Arzt
Fourth Service Command:		
Kennedy	250	Maj. Kurt Adler
Lawson	200	Capt. Charles L. Yeager
Northington	112	Capt. Frederick C. Redlich
Fifth Service Command:		
Ashford	100	Capt. Ralph W. Barris
Baker	150	Capt. Henry V. Agin
Nichols	200	Maj. (later Lt. Col.) Samuel Rebach
Wakeman	200	Capt. Charles H. Richards
Sixth Service Command:		
Percy Jones	150	Maj. D. Bernard Foster
Mayo	100	Capt. John A. Aita
Seventh Service Command:		
O'Reilly	200	Capt. (later Maj.) Samuel C. Little
Eighth Service Command:		
McCloskey	190	Maj. Francis Reisenman
Ninth Service Command:		
Bushnell	216	Maj. Samuel M. Schindelheim
DeWitt	100	Capt. (later Maj.) Manuel Sall
Hammond	250	Capt. (later Maj.) Charles W. Sult, Jr.
McCaw	100	Maj. Frederick D. Geist

Personnel

With the establishment of neurological centers came the need to staff and equip them. This problem presented considerable difficulties as neurologists and psychiatrists were grouped together under the same MOS (military occupational specialty) number. It was necessary to examine the qualifications of all members of both specialties in order to select those who had sufficient training to supervise a neurological section. This was a tedious task and led to later proposals that neuropsychiatric officers be more specifically classified according to their field of specialized training. Most qualified neurologists were selected on the basis of personal knowledge of their capabilities; others, on their recorded qualifications. These officers

were assigned to head the neurological sections in the centers and were assisted by officers who had had considerable postgraduate neurological training. This group, however, was insufficient to cope with the caseload. Therefore, arrangements were made with the Army School of Military Neuropsychiatry at Mason General Hospital, Brentwood, Long Island, N.Y., and with Columbia College of Physicians and Surgeons and New York University School of Medicine, both in New York City, N.Y., whereby student medical officers who had completed the established 90-day course in neuropsychiatry and had neurological aptitude would be given an additional 30 days' training in clinical neurology and electroencephalography at Mason General Hospital. Upon conclusion of this training, these officers were assigned to the various neurological centers where, under the continued guidance of their section chiefs and with experience, they became proficient assistants and proved of great value.

Despite the accelerated training program to produce young neurologists, the shortage continued, particularly in the staffing of station and general hospitals. For this reason, service command consultants in medicine and neuropsychiatry requested permission to place qualified internists in neurological centers for a period of training. This was discussed and approved by the Divisions of Medicine and Neuropsychiatry in the SGO. On 13 August 1945, Col. (later Brig. Gen.) William C. Menninger, MC, Director, Neuropsychiatry Consultants Division, submitted a letter to The Surgeon General giving the recommended procedure and detailed suggested course of instruction. These suggestions were favorably received, and centers for training were designated by the respective service commands. It was emphasized that the internists with this training in neurology were to function within their capabilities and to refer patients presenting special diagnostic problems to the appropriate neurological center. However, with the cessation of hostilities with Japan, with the gradual decrease in patient census, and with the projected closing of many of the hospitals, this program never materialized.

Electroencephalography

Development

The use of electroencephalography by the Army Medical Corps commenced shortly after 18 July 1942 at which time the Grass Instrument Co., of Quincy, Mass., shipped the first 4-channel model II instrument to Walter Reed General Hospital where the first electroencephalography laboratory was established by Capt. (later Maj.) Ephraim Roseman, MC. Somewhat later, the second instrument was installed at Darnall General Hospital, Danville, Ky.; in January 1943, another electroencephalography laboratory was started at Lawson General Hospital, Atlanta, Ga.

By April 1944, the widespread need for reliable diagnostic electro-

encephalography had become evident. Because the specialty was so new, technicians for maintenance and operation and medical officers capable of supervision and interpretation of tracings were practically nonexistent. Earlier sporadic training had been attempted at Walter Reed General Hospital as an on-the-job endeavor, but the personnel so trained were used locally and there was at that time no official recognition of the specialty. Somewhat earlier, Major Everts had commenced a systematic attack upon the problem of providing enlisted personnel trained for maintenance and operation, and medical personnel trained for interpretation and supervision. Since that time electroencephalography has been linked to neurology as an important subspecialty.

Dr. Frederick A. Gibbs, the civilian consultant in electroencephalography, with Major Everts, furnished information on electroencephalography which was published as TB MED 74 and issued on 27 July 1944. This publication described the uses and limitations of electroencephalography and gave a lucid description of what was adopted as the standard procedure for taking the tracings and for their interpretation. Before the issuance of TB MED 74, there had been no standards for electrode positions or combinations, and tracings taken in one hospital were rarely understood by qualified physicians of another hospital to which a patient might be sent.

Training

Technicians.—The training of noncommissioned personnel at the same school at which medical neurologists were also being trained also proved to be a wise decision. The limited size of the classes in electroencephalography at the School of Military Neuropsychiatry permitted the blending of objectives. In some cases, a supervising officer and the technician who was to serve with him were trained simultaneously. The technician trainees were principally drawn from radar technician schools of the Signal Corps, which were operating at full capacity and could release the overflow of candidates. The enlisted personnel so selected easily adapted themselves to servicing the Grass equipment then in use and, ordinarily, were competent for maintenance work within a month of the start of training. Training in the application of electrodes and in the sequence of electrode combinations required for the standard tracing consumed more time. It was conducted mainly by WAC (Women's Army Corps) technicians previously trained in the School's laboratory. Upon completion of training, ordinarily 3 months, the trainees were assigned to Zone of Interior or oversea posts where laboratories were most needed.

Officers.—Medical officers selected were given 4 weeks' intensive training. The electroencephalographic material presented under the tutorship of Maj. James L. O'Leary, MC, was divided into four parts, as follows:

1. Survey of the rudiments of electronics with emphasis upon the prin-

ciples of electronic amplification and upon the construction of the Grass Encephalograph, maintenance of this machine, and potential field theory.

2. Review of the developments of knowledge of bioelectric potentials as applied to the understanding of cortical rhythms.

3. Practical training in obtaining standard 4- and 6-channel EEG's in accordance with the procedures given in TB MED 74.

4. The method of classification of records adapted by the Army, practical experience in the diagnosis of records, and the writing of concise meaningful reports.

The essential material available for the program included two skulls, a 6-channel electroencephalograph, and illustrations, reprints, and other materials pertaining to the subject. A set of 106 record strips prepared for the Army by Dr. Gibbs was studied intensively by each student, and this served the purpose of introducing the classification system which had been adopted. The principles of localizing foci of abnormal activity by phase reversal and triangulation were taught, using an artificial brain within which a movable source of electrical potential was placed. When electrodes were applied to this model and connected to the machine, actual recording conditions were simulated, and test problems were given the students. This expedient made up for the lack of sufficient cases which could be used to study localization procedures.

By the war's end, the School of Military Neuropsychiatry had graduated 56 medical officers and 23 enlisted men and women who had been trained in electroencephalography. From three other courses which had been established at Walter Reed, DeWitt, and Brooke General Hospitals, a smaller number of trainees were graduated.

A total of 41 electroencephalographs were installed in medical treatment facilities in the Zone of Interior—35 in ASF hospitals and 6 in AAF (Army Air Forces) installations—as follows:

Installation	*Location*
General hospitals:	
Ashford	White Sulphur Springs, W. Va.
Baxter	Spokane, Wash.
Birmingham	Van Nuys, Calif.
Borden	Chickasha, Okla.
Brooke	Fort Sam Houston, Tex.
Bruns	Santa Fe, N. Mex.
Bushnell	Brigham City, Utah
Crile	Cleveland, Ohio
Cushing	Framingham, Mass.
Darnall	Danville, Ky.
DeWitt	Auburn, Calif.
Fitzsimons	Denver, Colo.
Halloran	Staten Island, N.Y.
Hammond	Modesto, Calif.
Hoff	Santa Barbara, Calif.
Kennedy	Memphis, Tenn.

General hospitals—Continued	*Location*
LaGarde	New Orleans, La.
Lawson	Atlanta, Ga.
Letterman	San Francisco, Calif.
Lovell	Ayers, Mass.
Mason	Brentwood, Long Island, N.Y.
Mayo	Galesburg, Ill.
McCaw	Walla Walla, Wash.
McCloskey	Temple, Tex.
McGuire	Richmond, Va.
Newton D. Baker	Martinsburg, W. Va.
Nichols	Louisville, Ky.
Northington	Tuscaloosa, Ala.
O'Reilly	Springfield, Mo.
Percy Jones	Battle Creek, Mich.
Thomas M. England	Atlantic City, N.J.
Tilton	Fort Dix, N.J.
Valley Forge	Phoenixville, Pa.
Wakeman	Camp Atterbury, Ind.
Walter Reed	Washington, D.C.
AAF installations:	
Convalescent Hospital	St. Petersburg, Fla.
Convalescent Hospital	Fort Logan, Colo.
Regional Hospital	Maxwell Field, Ala.
Regional Hospital	Coral Gables, Fla.
Regional Hospital	Army Air Field, Lincoln, Nebr.
Regional Hospital	Hammer Field, Fresno, Calif.

Five machines were sent to the European and Mediterranean theaters and six to the Pacific areas. Others were later sent to Japan to serve postwar purposes with the army of occupation.

Posttraumatic epilepsy center

In October 1945, a posttraumatic epilepsy center was established at Cushing General Hospital.[4] For 1 year, this center was concerned with the specialized aspects of head injury, after which it transferred to the VA (Veterans' Administration). It is important to record that Metrazol (pentylenetetrazol) activation was first introduced at this center in the fall of 1945. Electrocorticography, with particular emphasis upon afterdischarge from cortical stimulation, was also developed during a study upon the posttraumatic epileptics.

Statistical data

The following data, tabulated by Major Everts and Major Ross in October 1945, were reported by 18 of 19 Zone of Interior special neurological centers:

[4] Medical Department, United States Army. Surgery in World War II. Neurosurgery. Volume I. Washington: U.S. Government Printing Office, 1958, pp. 279–317.

	Number	*Percentage abnormal tracings*
Total EEG's performed	21,247	49
Posttraumatic encephalopathy	6,144	55
Total epilepsies	2,697	60
Total expanding intracranial lesions	165	70

ORGANIZATION OVERSEAS

Hospitals

There were no neurological centers in oversea theaters similar to those established in the continental United States. Tables of organization for station and general hospitals provided for one to three officers on the neuropsychiatric staff. Because there were so many hospitals overseas, the available neurologists and psychiatrists were distributed sparsely. Usually, however, in hospital centers, a neurologist was assigned, as were specialists in other fields, to be consultant to the center hospitals and, thus, was called upon for the more severe neurological problems.

As a rule, neurological cases were admitted to hospitals caring for diseases and injuries in general. There were a few station and general hospitals in the European, Mediterranean, and Pacific theaters which had been designated as special neuropsychiatric centers. But in these installations there was such a heavy preponderance of psychiatric cases that neurological conditions, for the most part, continued to be cared for in the general hospitals.

Electroencephalography

European theater.—Information concerning oversea operations in electroencephalography was scattered and difficult to substantiate. The first EEG instrument known to have been officially sent overseas for American military use arrived in June 1944, at the 96th General Hospital, Malvern, England. Maj. Alexander Ross, MC, the assigned neurologist, appears to have had the only functioning electroencephalography laboratory in the European theater before the close of World War II. He was aided by Capt. James H. Lasater, MC, and an EEG technician. Their EEG machine was later turned over to Maj. Ephraim Roseman, MC, who had been sent overseas with two technicians in April 1945. Because of delays, Major Roseman was unable to have his laboratory in Paris operational until the war in Europe had ended.

Mediterranean theater.—Lt. Cols. Theodore J. C. von Storch, MC, and Benjamin Boshes, MC, had EEG equipment operating in Italy and North Africa. Colonel von Storch, chief of the Neuropsychiatry Section, 33d General Hospital, had the EEG equipment mounted on an ordnance truck for field use in the Italian campaign. His team, which studied blast con-

Africa. Colonel von Storch, chief of the Neuropsychiatry Section, 33d General Hospital, had the EEG equipment mounted on an ordnance truck for field use in the Italian campaign. His team, which studied blast concussion cases, consisted of a neuropsychiatrist, a psychologist, two technicians, and a driver. Initially the team functioned at the 8th Evacuation Hospital, during the Apennines campaign, on Route 65 south of Bologna; later, they followed the Fifth U.S. Army offensive into the Po Valley. The team's findings from their study of blast concussion are given on pages 542–544.

Colonel Boshes operated his electroencephalography laboratory at the 12th General Hospital. Electroencephalographs were taken on head injuries of various types, for "exhaustion" (neuropsychiatric casualties), in followup studies on electroshock therapy, and on a large number of seizure cases. Colonel Boshes carried out a standardized hydration experiment with electroencephalography upon those seizure cases in which the etiology was in question.

The studies of Colonels von Storch and Boshes placed emphasis upon the importance of obtaining EEG studies early, particularly in traumatic conditions.

ADMISSION AND DISPOSITION

On the whole, neurological diseases encountered in the Army were not much different from those observed in the civilian population. They comprised 1.1 percent of all admissions for disease. There were some 174,422 admissions for neurological disorders in World War II, indicating an overall admission rate of 6.9 per 1,000 mean strength per year. The largest admission rate was in 1943, the lowest, in 1945 (8.3 and 6.0 for these years, respectively). As may be seen from table 60, the specific diagnoses exclude neurosyphillis, infectious meningitis, and others alike, not considered by established policy within the proper province of neurology. Of the specific diagnoses, neuralgia, neuritis, and polyneuritis indicate the highest admission rates, followed by those for epilepsy, trauma of the central nervous system, and herniated nucleus pulposus. (See chapter IX, table 7 and chart 2 for neurological admissions in World War II, by month.)

While most of these conditions rightfully come within the province of the neurologist, established policy dictated that some, notably infections of the nervous system such as neurosyphilis and the infectious meningitides, be supervised by the appropriate medical specialist with the neurologist functioning as a consultant.

Disposition of patients with neurological disorders depended upon severity, degree of disability, response to therapy, existence of the disease before service or occurrence after induction, prognosis, potential incurrence of Government liability, and functional capacity on a limited duty status or by change of environment. These factors were also governed by prevailing administrative directives, an example of which was WD Circular No. 212, of 29 May 1944, prohibiting the return to duty of patients without special qualification who could not do a reasonable day's work.

Some 52,200 persons were separated in World War II from the Army

TABLE 60.—*Admissions for neurological conditions, by diagnosis and year, U.S. Army, worldwide, 1942–45* [1]

Diagnosis	Total 1942–45		1942		1943		1944		1945	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Degenerative neurological diseases	2,736	0.1	678	0.2	1,053	0.2	505	0.1	505	0.1
Infections of nervous system	7,688	0.3	1,141	0.4	3,017	0.4	1,890	0.2	1,640	0.2
Peripheral nervous system disorders:										
Neuralgia, neuritis, and polyneuritis	56,311	2.1	6,730	2.1	14,406	2.1	20,575	2.7	14,600	2.1
Herniated nucleus pulposus	11,523	.5	710	.2	3,348	.5	3,510	.5	3,955	.5
Paralysis	8,252	.3	1,073	.3	1,884	.3	2,055	.3	3,240	.4
Other peripheral nerve diseases	996	.0	---	0	1	.0	505	.1	490	.1
Total	77,082	3.0	8,513	2.6	19,639	2.9	26,645	3.5	22,285	3.1
Paroxysmal disorders and disturbances of consciousness:										
Epilepsy	18,077	0.7	4,115	1.3	6,542	1.0	4,465	0.6	2,955	0.4
Other	36,716	1.5	5,184	1.5	15,882	2.2	8,345	1.0	7,305	1.0
Total	54,793	2.2	9,299	2.8	22,424	3.2	12,810	1.6	10,260	1.4
Trauma of central nervous system	11,855	0.5	491	0.2	4,749	0.7	3,310	0.4	3,305	0.4
Miscellaneous disorders of the nervous system	20,268	0.8	2,337	0.7	6,296	0.9	5,385	0.7	6,250	0.8
Total neurological disorders	174,422	6.9	22,459	6.9	57,178	8.3	50,545	6.5	44,240	6.0

[1] The diagnostic nomenclature and classification used for the presentation of World War II data on morbidity, separation, and mortality are those adopted by the Army in 1944 and used for 1944 and 1945 records. Therefore, the data for diseases which in 1942 and 1943 were differently named or grouped, or both, were renamed in equivalent or closely equivalent terms of the 1944–45 diagnostic nomenclature and regrouped accordingly. (For further details see footnote 1 to table 6, chapter IX.)

NOTE.—The entry .0 indicates a rate of less than 0.05.

for disability due to neurological disorders; 50,105 of these persons were enlisted men discharged on CDD (certificate of disability for discharge) (table 61). In general, the principal causes of admissions were also the principal causes of the disability separations. Epilepsy was the leading cause of separation (28.9 percent of the disability separations for neurological disorders), followed by encephalopathy and other posttraumatic conditions of the central nervous system (16.4 percent), and by herniated nucleus pulposus (10.8 percent) (table 62).

It is of interest to note that in World War II discharge rate for neuro-

logical disorders was identical to that of World War I. The discharge rate was 2.2 per 1,000 mean strength per year in both World War II and World War I. (See appendix A, table 10.)[5] (The discharge rates for neuro-

TABLE 61.—*Separations for neurological conditions, U.S. Army, by diagnosis and year, worldwide, 1942–45*

Diagnosis	Total (1942–45)	1942	1943	1944	1945
	Total U.S. Army Personnel				
Epilepsy	15,103	2,589	5,398	3,940	3,176
Encephalopathy and other posttraumatic conditions of the central nervous system	8,565	208	3,025	2,514	2,818
Herniated nucleus pulposus	5,658	188	1,412	1,167	2,891
Neuralgia, neuritis, polyneuritis	5,201	275	1,562	1,143	2,221
Paralysis of part or all of one or both upper extremities	1,752	93	124	622	913
Paralysis of part or all of one or both lower extremities	868	41	77	374	376
Hemiplegia	651	89	215	176	171
Paraplegia	346	37	89	147	73
Facial paralysis	428	23	85	95	225
Paralysis, other and unspecified	1,864	29	435	199	1,201
Neurological diseases, other	11,764	1,231	4,584	2,739	3,210
Total	52,200	4,803	17,006	13,116	17,275
	Enlisted Men				
Epilepsy	14,633	2,559	5,258	3,735	3,081
Encephalopathy and other posttraumatic conditions of the central nervous system	8,317	205	2,990	2,389	2,733
Herniated nucleus pulposus	5,386	186	1,384	1,113	2,703
Neuralgia, neuritis, polyneuritis	4,991	270	1,523	1,077	2,121
Paralysis of part or all of one or both upper extremities	1,709	92	124	606	887
Paralysis of part or all of one or both lower extremities	848	40	76	370	362
Hemiplegia	630	89	214	163	164
Paraplegia	341	37	89	143	72
Facial paralysis	412	22	84	92	214
Paralysis, other and unspecified	1,824	28	426	186	1,184
Neurological diseases, other	11,014	1,193	4,418	2,432	2,971
Total	50,105	4,721	16,586	12,306	16,492

[5] Discharges for psychosis were also similar in both World War I and World War II, which might indicate that these conditions (neurological and psychotic) are unaffected by external conditions (stress). —A. J. G.

TABLE 62.—*Percent distribution of separations for neurological conditions, U.S. Army, worldwide, by diagnosis, 1942–45*

Diagnosis	Percent	
	Total Army	Enlisted men
Epilepsy	28.9	29.2
Encephalopathy and other posttraumatic conditions of the central nervous system	16.4	16.6
Herniated nucleus pulposus	10.8	10.7
Neuralgia, neuritis, polyneuritis	10.0	10.0
Paralysis of part or all of one or both upper extremities	3.4	3.4
Paralysis of part or all of one or both lower extremities	1.7	1.7
Hemiplegia	1.2	1.3
Paraplegia	.7	.7
Facial paralysis	.8	.8
Paralysis, other and unspecified	3.6	3.6
Neurological diseases, other	22.5	22.0
Total	100.0	100.0

logical disorders are shown in chapter IX, table 3 and chart 1, by month.)

Apparently there is a stability about neurological disturbances which permits a certain amount of predictability.

COMMON CLINICAL DISORDERS

Trauma to the Central and Peripheral Nervous Systems

No stereotyped system of management of all types of nervous system trauma was considered feasible since each case required individual discrimination. However, in general, the wounded soldier with neurosurgical or neurological complications received care and treatment through the usual evacuation chain. These patients presented problems of neurosurgical, neurological, and psychological importance, and while ideally it would have been desirable to have all three services complementing each other from the beginning, this was impractical. There was a shortage of personnel in each specialty, and in the early phases of treatment, the neurosurgeon often had to be neurologist and psychiatrist as well. This was not ideal, particularly from the psychological standpoint, for being under the care of only the neurosurgeon unwittingly placed emphasis upon severe and perhaps irreparable injury. This was particularly true in cases of closed head injury where psychogenic symptoms were so prone to occur.

Differentiating cases with so-called posttraumatic encephalopathy

from those with psychogenic reactions to trauma was not always easy. Generally, the wounded person with organic defects had a nonrecoverable, retrograde amnesia; expressionless facies; memory and concentration defects; impaired abstract thinking; defective judgment and insight; impulsive and, sometimes, explosive behavior; and decreased intellectual function. Electroencephalography often lent support to the clinical impression. On the other hand, patients with psychogenic reactions were more complaintive, their faces were anxious, their symptoms radiated into multiple somatic spheres, and their memory defects were related to inattention and preoccupation. They were tense, showed autonomic instability, "resisted" improvement, and posed real problems in management.

Results of treatment in these questionable closed head injuries depended upon the attitudes, concepts, and interpretations of the hospital personnel. In some hospitals, there were rigid and biased reactions on the part of either the surgical or medical services—the patient's symptoms being considered entirely organic or entirely psychogenic. In others, the clinical services complemented each other so that a more balanced evaluation of cases was attained. This provided a broad therapeutic approach, combining neurosurgical, neurological, physical, and psychological techniques. Thus, emphasis was placed on progressive early activation, on performance of light duties, and on maintaining motivation for duty in the theater; hopes for secondary gain were suppressed; and neurotic mechanisms were attacked. Such management was effective, although, of course, it was still necessary to evacuate a good number of patients with fixed symptomatology to the United States.

This combined approach was also necessary in spinal cord and peripheral nerve injuries. Where neurosurgical care was no longer necessary, the problem became one of neurological and psychological management. It was not at all uncommon for patients to present combinations of organic and psychological disorder, some to a degree taxing the diagnostic acumen of the neurologist. A number of these recovered sufficiently to be restored to duty in the theater; others had to be evacuated.

Rehabilitation of the brain injured

The usual arrangement in the neurological-neurosurgical centers was for the Neurological Section to assume the care of patients with closed head injury and of those having open injuries after they had received necessary neurosurgical treatment. This task necessitated the cooperation not only of the professional services but also of numerous ancillary divisions. Upon completion of all necessary clinical neurological evaluations, the general procedures followed were:

1. Careful psychological testing to evaluate the patient's deficit.
2. Determination of pretraumatic personality as a contrast to posttraumatic deviation.

3. Special reconditioning and reeducational program coordinating occupational and physical therapy, educational moving pictures, classes, and exercise.

4. Psychotherapy sessions in which the patient received explanations, reassurance, and instructions, and was given a positive, hopeful attitude. Efforts were made to disabuse him of the idea of invalidism.

5. Red Cross and social service information, particularly concerning domestic and community factors.

6. Contacts with relatives to give them an understanding of the case and to enlist their cooperation.

7. Therapeutic trials at home after the patient was stabilized in order to obtain an indication of his reactions in such an environment. This was supplemented by a Red Cross report on the effects of his visit.

8. Evaluation of capabilities, interests, and aptitudes so as to give the patient understanding of his potentialities in seeking employment. Some hospitals kept abreast of the job possibilities and guided the patients into those for which they were best suited.

It was believed that these policies, with necessary modifications, proved their value and that a large proportion of patients were salvaged for useful lives.

Aphasic language disorders

Aphasic language disorders were seen with increasing frequency in the specialized general hospitals caring for neurological and neurosurgical patients. Most of these cases had resulted from severe head injuries sustained in combat. Many had, in addition to aphasia, other associated neurological defects of a motor or sensory nature and concomitant emotional and intellectual changes. Neurologists and neurosurgeons alike appreciated the fact that the language defects in most traumatic problems of the brain tend to improve spontaneously. For this reason, some of the professional consultants were initially hesitant to set up a special language program for the care of such patients, believing that it would entail unduly prolonged hospitalization for a relatively small group of patients. However, because it was realized that much could be done in speeding the healing progress, in directing improvement, and in influencing the patient's pathological reaction to his speech and other defects through skilled management, a program to this end was worked out by the Neurology Branch of the Neuropsychiatry Consultants Division.

The neurologist was made responsible for the early study and treatment of all aphasic disorders. His staff was properly augmented by the addition of a clinical psychologist who assisted in the evaluation of the brain-injured patient and collaborated with him in the speech training program. An enlisted or civilian speech therapist was assigned where the caseload made such additional help necessary.

In general, the terminology and principles enunciated in TB MED 155, issued in April 1945, were followed, being elaborated upon by individual staffs as experience was gained.

Those cases with surgical implications received the collaborative attention of neurosurgeon and neurologist so that the patient might receive speech training early, with other treatment measures, and be accordingly advanced in his training. Upon conclusion of surgical procedures, the patient was transferred to neurology for further rehabilitation.

Voice recorders and other related apparatus were utilized in this program. Some special training materials were obtained, usually from sources outside the Army, such as the Red Cross and university clinics particularly interested in the subject.

Patients with aphasia due to brain trauma sometimes made amazing improvement, certainly more than had been experienced in the average civilian case. This may be attributed to their comparative youth, early definitive treatment, and availability of good hospital care; to the hopeful spirit of youth; to the specialized attention of therapists; and to the general encouragement, banter, reciprocal aid, and interdependence found in a group of young men in military hospitals. In any event, those concerned in this restitution program received ample reward in the satisfaction of seeing many of their patients regain function.

It was estimated that the average aphasic patient remained in the hospital for about 6 months. Although some made astonishing improvement and others made sufficient progress to function acceptably outside the hospital, a minority showed little progress. Consequently, arrangements were made with the Veterans' Administration to designate certain of their hospitals for the prolonged care and rehabilitation of severe or unimproved aphasic patients.

Peripheral nerve injuries

Although the subject of peripheral nerve injuries perhaps more properly belongs to the neurosurgeon, the preoperative and postoperative management of nerve injuries is of prime interest to the neurologist. Each neurological-neurosurgical center had its own arrangements for the management of these cases; in all, however, the liaison between neurology and neurosurgery was closely knit and effectively maintained. In some centers, patients with peripheral nerve injuries were admitted to the neurosurgical service and remained there throughout hospitalization, being examined at intervals by the neurologist as consultant. In others, they were admitted to the neurological service with the neurosurgeon as consultant. If operation was agreed upon, the patients were transferred to neurosurgery and remained there until discharge. Still other centers, more ideally, admitted all severe nerve injuries to the neurological service where complete examinations were performed. If operation was indicated, the patients were

transferred to neurosurgery. After the need for surgical supervision was removed, these patients were returned to the neurological service which assumed the responsibility of followup examinations, retraining, rehabilitation, and discharge. This freed the surgeon for his prime purpose and gave the neurologist splendid opportunities to study the restitution of the damaged nerve and its areas of supply.

An example of this last-mentioned type of organization was that at Cushing General Hospital. Maj. (later Lt. Col.) Frederic H. Lewey, MC, who was chief of the Neurology Section at that hospital, described the procedures routinely employed on every patient with peripheral nerve injury, as follows:

1. The muscular power is examined by means of the so-called "fish-hook" method. An ordinary spring scale is applied to measure the force in pounds required to overcome the voluntary resistance of a certain muscle. The average values for the various muscles and their standard deviations have been determined in a large random sample of normal soldiers. Experience has shown that this method of examination is not more time consuming than the old one of estimating arbitrarily the loss of power in percentage of the normal, and that the method of mere estimation gives, even in the hands of experienced neurologists, utterly incorrect information when compared with the power actually determined.

2. The muscle atrophy accompanying denervation is recorded and its recovery checked by hand and foot prints which give at the same time a graphic impression of the trophic condition of the skin.

3. The earliest possible detection of the presence or return of innervation is of singular importance in judging the prognosis of a nerve injury of unknown character. It may mean foregoing an operation with unnecessary waste of the surgeon's time, or it may mean, on the other hand, saving months of time by urging immediate exploration of a nerve.

a. No one method of studying the electrical irritability of the nerve-muscle apparatus has so far been satisfactory in these endeavors. It is attempted to determine whether any and which method gives the best results by repeated comparison of the electromyogram, the strength-duration curve, and the cathode-closing tetanus of the same patient with his clinical course.

b. Many months of hospitalization are saved by determining the permeability or impermeability of a nerve scar or suture 8 to 12 weeks after exploration or suture instead of after 8 to 12 months. Operation under local anesthesia and stimulation of sensory fibers distal to scar or suture has proved to be by far the most sensitive method. However, it is a qualitative method and does not give a reliable indication of the type and number of nerve fibers passing the injury and of the prognosis for recovery. Recording, during operation, the amplitude, and latency of action currents, elicited across the injury, permits a better quantitative insight into the type and number of viable nerve fibers in the peripheral stump.

c. The determination of the injury current of an interrupted nerve is tried to decide how much of the nerve should be resected to reach a good cross section of nerve fibers.

4. Sweat tests are recorded in peripheral nerve injuries, especially in connection with the determination of the skin temperature by means of thermocouples before, during, and after injection of sympathetic ganglia for causalgic type pain prior to sympathectomy.

5. Many patients arrive from overseas in casts, applied for fracture or instead of a splint, with a frozen joint. They have to be mobilized before neurosurgery can be

contemplated. The facilities of the physiotherapeutic section do not allow treatment of more than 20 minutes daily per patient. A mechanical apparatus for the automatic movement of wrist, elbow, and knee joints has been improvised which can be run and regulated by the patients themselves and permits treatment of our patients three times a day for one-half hour each. Experience has shown that the necessary mobilization is performed 25 to 30 percent faster than by the old methods of manual movement, freeing, in addition, a physiotherapist.

6. Each patient is presented at the end of his examination—as a rule one week after admission—to a combined conference every Saturday morning in which the staffs of the neurological and neurosurgical sections, the chiefs of medicine and surgery, representatives of the orthopedic and physiotherapy section and sometimes the plastic surgeons participate. A decision is made whether a patient needs operation and if so, what kind, in which sequence, and whether in combination with plating fractures or plastic repairs. This conference reduces the consultation service to a minimum.

7. Patients are transferred after an operation to the neurosurgical wards where they remain until the sutures are removed and the extremity again extended. Thereafter, they return to the neurological section.

8. The recovery from and the regeneration of a nerve injury or suture takes many months, often more than a year. No patient must be discharged from the hospital and the Army until he has attained maximum hospital benefit. It is distressing for patients and medical officers alike to see the patients sit around for weeks and months, frequently morose and useless, but occupying a bed that could be used to much better avail for a seriously ill person. A prolonged work furlough has been introduced in this section with excellent results. The patient who exercises his injured extremity grudgingly 3 or 4 hours daily while in the hospital does it gladly 10 hours a day when paid ten dollars in a factory. He is proud to help effectively the war effort, and his own pocketbook at the same time. Industry is grateful for the increase in manpower. The patient is returned to this Hospital not later than 3 months for a checkup of his improvement and decision as to whether and when he is ready for CDD. The opportunity of gradual adjustment to civilian life after years of Pacific or European warfare has been considered a great help by most of the patients.

Several hundred patients have been converted at the present time in this way from in-patients to out-patients, freeing permanently the corresponding number of beds for fresh patients.

Of the first 500 patients with peripheral nerve injuries discharged from the Army at Cushing General Hospital, 58 percent recovered without any surgical procedure, 16 percent had nerve sutures, and 26 percent had surgical explorations, in half of which local pathology was corrected.

Blast concussion

World War II afforded an unexcelled opportunity to study the effect of explosive blast upon the central nervous system.[6] It must be admitted, however, that, while better understanding of the condition occurred and existing concepts expanded, no final decision concerning its organic and psychogenic nature was reached.

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[6] (1) Medical Department, United States Army. Internal Medicine in World War II. Activities of Medical Consultants. Volume I. Washington: U.S. Government Printing Office, 1961, pp. 377–380. (2) Medical Department, United States Army. Surgery in World War II. Neurosurgery. Volume I. pp. 215–260.

Mediterranean theater.—The following excerpts have been abstracted from the report of a study conducted in the Mediterranean theater:[7]

The original purpose of the study was two-fold: (1) To determine whether such a delicate instrument as the electroencephalograph could be transported over difficult terrain under combat conditions and utilized effectively in forward areas. It was demonstrated that such could be done, if not with ease, yet well within the realm of utility. (2) To examine patients with cerebral blast concussion as soon as possible after injury and to evacuate as many as possible to a similar (nonmobile) unit in the 12th General Hospital at Leghorn where subsequent developments could be studied by similar means. It was thus hoped to gather useful information pertaining to the mechanism, diagnosis, treatment, cause, and prognosis in such cases.

Although the plan was not carried out exactly as planned because of the tactical situation and the type of war being waged at the time (April 1945) in the Po Valley, it proceeded mainly as a field operation.

The study consisted of a comparative analysis of 82 cases of various types and degrees of cerebral concussion as observed soon after injury. In 16 of the cases, repeated examinations were made from 2 to 105 days after injury. The cases were divided into two types: Those subjected to blast injury (B), and those subjected to direct blow by a solid object such as a shell fragment, moving vehicle, and the like (S).

Each of these groups was analyzed with respect to—

1. Evidence and degree of concussion (unconsciousness, amnesia, confusion).
2. Subsequent symptoms (headache, tinnitus, deafness, vertigo, giddiness).
3. Time elapsed between injury and examination.
4. The presence and relative significance of pathology as determined by:
    (a) Craniofacial injury.
    (b) Neurologic examination.
    (c) Electroencephalographic examination.
    (d) Psychometric examinations.
5. Localizing value of these various examinations.
6. Detailed analysis of the encephalographic changes.

The results of the study were as follows:

1. Electroencephalography can be performed adequately in the field with a mobile unit.

2. Few of the blast cases showed any evidence of encephalopathy longer than 2 days after injury other than abnormalities of cortical electrical activity. These changes persisted up to 12 days and in one case as long as 105 days after injury. Patients subjected to direct cranial injury

[7] Von Storch, T. J. C., and Kounin, J.: A Study of Cerebral Concussion. *In* Annual Report, 33d General Hospital, 1945.

by a solid object showed more evidence of injury than the blast cases. This encephalopathy persisted longer and could be demonstrated by neurologic as well as electroencephalographic examination. Properly speaking, these cases exhibited cerebral contusion rather than concussion.

3. Unconsciousness was used as a criterion of concussion. Pretraumatic amnesia occurred in 86 percent of the cases concussed by an object but in only 9 percent of those due to blast. Pretraumatic amnesia was present also in 10 percent of the cases with considerable psychogenic complications. Posttraumatic amnesia and confusion were of little value in determining the presence of concussion.

4. The presence of headache, tinnitus, deafness, giddiness, or vertigo bore no significant relationship to the presence of cerebral concussion.

5. Craniofacial injury was present in varying degree in all groups and was of no value in determining the presence of cerebral concussion.

6. Neurologic examinations were most frequently positive in the cases with relatively severe injury due to blow by an object. They were not of much value in blast cases.

7. Psychometric examinations were of the same significance as the neurologic examinations.

8. Electroencephalography revealed encephalopathy most frequently and of greatest degree in those more severely injured by a solid object. On the other hand, cortical electric dysrhythmias were present in approximately one-half of those patients who were not rendered unconscious. Hence, the electroencephalogram either revealed—

(a) A subclinical encephalopathy, or

(b) Other cerebral dysrhythmias unrelated to concussion.

9. Detailed analysis of the electroencephalogram revealed that—

(a) Patients with cerebral concussion due to blow by an object tended to show normal or low voltage, normal or random frequency of mild to moderate degree with bursts of abnormal (high voltage slow) activity mild to severe in degree, mild to considerable evidence to focal damage, and little or no response to hyperventilation.

(b) Patients with cerebral concussion, due to blast, tended to show normal voltage and frequency with mild random activity, slight evidence of focal pathology and no reaction to hyperventilation.

(c) Those cases in either group who were not rendered unconscious had entirely normal records, as a rule, except in those who were in the proximity of a blast, fast activity and occasional bursts were evident. In both groups, there was a tendency to a slight response to hyperventilation.

(d) The cases with significant psychogenic complications had a slight tendency to low voltage records with mild random activity, slight bursts but considerable reaction to hyperventilation. These records were

often of the psychomotor type and probably represented preexistent cerebral dysrhythmias.

10. Reliable evidence of focal encephalopathy was most frequently found by neurologic examination in the patients more severely injured by direct blow with a solid object.

11. The investigation was inconclusive but revealed sufficient information to warrant further studies.

European theater.—A detailed clinical study of blast injury was carried out in the European theater by Maj. Howard D. Fabing, MC,[8] at the 130th General Hospital. The following summary is from his report:

Study of 80 consecutive cases of blast injury in combat soldiers was carried out. It was found that the disorder occurs among all ranks, in new troops as well as in veterans of combat. All type of explosive agents can cause the disorder. Some soldiers become blast victims following single nearby explosion, others succumb as the result of the cumulative effect of a barrage. The unconsciousness produced by blast is characterized by a retrograde amnesia for the sound of the explosion and anterograde amnesia of variable length, but lasting an hour in the usual case. The unconsciousness is seldom characterized by coma, but rather by dissociated aimless behavior. Upon return to consciousness the patient complains of protracted headache which is nonspecific in position or quality and which may be constant or intermittent. In addition, he complains of tinnitus which is usually non-persistent, and of diffuse anxiety symptoms. About one half of the patients complain of generalized somatic soreness for a day or two after blast injury. They show no evidence of focal central nervous system damage on neurological examination, and few have bleeding from any of the orifices. Study of their spinal fluids show normal pressure, and normal cellular and protein content. Bleeding into the fluid is extremely rare (2.5 percent).

A successful method of therapy was discovered during an inquiry into the nature of the unconsciousness of these patients. It was found that memory for the unconscious period could be recalled under chemical hypnosis; that it was therefore an amnesia of the type seen in hysteria. Furthermore, it was noted that there was a dramatic relief of symptoms in cases in which there was good conscious recall for the amnesia's material.

Clinical experimentation with the technique of chemical hypnosis led to a modification which proved successful in bringing about recovery of post-blast amnesia. The method employs sodium pentothal intravenously to produce chemical hypnosis and exploration of the amnesic material, followed by rapid waking with intravenous coramine. The technique is described in detail. It proved of therapeutic value in more than 90 percent of cases.

The problem of individual susceptibility to blast injury is raised. The relationship between blast injury and head injury is pointed out, and it is demonstrated that the pentothal-coramine treatment technique can be employed successfully in some cases of the chronic sequelae of head injury as well as in blast injury.

It is concluded that so-called blast injury is in more instances a disturbance in higher nervous physiology, i.e., that it is a psychoneurosis. A neurophysiologic theory of the pathogenesis of blast injury [along Pavlovian lines] is advanced, and an attempt is made to understand the neural mechanism of chemical hypnosis in these cases. It is noted that this formulation is consistent with current psychodynamic theory, the difference being one of terms. It is pointed out that study of the mechanisms of the

[8] Fabing, H. D.: Cerebral Blast Syndrome in Combat Soldiers. Tr. Am. Neurol. A. 71: 29—33, June 1946.

production of blast injury may lead to a better understanding of the neural basis of other more complex neuroses.

The preceding two reports detail the opinions formulated on relatively early cases of the blast syndrome. The opportunity to evaluate later cases occurred at the 96th General Hospital and in the Zone of Interior where patients were admitted several weeks after the injury and after having passed through several consecutive hospitals. These evacuated patients continued to complain of intractable and generalized headache, giddiness, irritability, impaired concentration, nonretentive memory, blurring of vision, and trembling. Examination revealed little other than hyperhidrosis, hyperactive reflexes, and fine hand tremor. A psychiatric investigation almost invariably disclosed the existence of material of strong emotional tone antedating the explosion. Any existing anxiety was aggravated during the chain of evacuation by the all too frequent diagnosis of "cerebral concussion due to blast." This contributed to the fixing and focalizing of symptomatology thus posing difficult problems in therapy. The syndrome was so typical of anxiety state with some conversion features that psychotherapy was obviously the treatment of choice. This often produced encouraging results.

From evidence available, the conclusion seemed inescapable that while an actual brain injury due to blast may occur, this is rare, and that in the vast majority of such cases, there is an antecedent emotional unrest, a sudden overwhelming of psychic defenses, and then anxiety and conversion symptoms.

Epilepsy

Admissions for epilepsy in World War II constituted somewhat over 10 percent of all admissions for neurological conditions (table 60), and as indicated before, the disability discharges for epilepsy constituted some 29 percent of all disability discharges for neurological disorders. Idiopathic grand mal was the most frequent expression of the disorder. Many soldiers had deliberately concealed their affliction at the time of induction hoping that the regularity and training of military life would be beneficial; others, because they were thwarted from obtaining jobs in civilian life or had repeatedly lost them. Many had the inception of seizures during military service, and it is possible that the rigors, responsibilities, excitement, fatigue, and frustrations of such an existence were precipitating factors. It was characteristic of most of these persons with epilepsy, however, to be strongly motivated to remain in service. The soldier with epilepsy minimized his affliction, was irked at hospitalization, and, as a rule, either objected to separation or resigned himself to this procedure. This attitude was in distinct contrast to that of the neurotic who, because of "fainting spells," was admitted to the hospital to be observed for epilepsy.

About 13 percent of patients with open head wounds developed epi-

lepsy; of these, penetrating injuries produced the greatest number. A relatively small number of epilepsies occurred as a symptom of brain tumor, brain abscess, or inflammatory cerebral disease.

The ordinarily accepted methods in the diagnosis and treatment of epilepsy were followed. Explanation and superficial psychotherapy were employed in addition to drugs. The Red Cross made available, to appropriate patients, literature of the American Epilepsy League as an educational guide.[9] Surgical procedures were used where indicated. The Posttraumatic Epilepsy Center at Cushing General Hospital has already been mentioned (p. 531).

Although it is realized that the indiscriminate acceptance of epileptic persons into military service would be imprudent, it would appear that, for those of normal intelligence, with few seizures, and with adequate premonitory symptoms, a place could be found. They could perform clerical or manual duties of a nature not dangerous to themselves or others and, thus, not only contribute to the national effort but also gain, in addition, the satisfaction of accomplishment too often denied them.[10]

Peripheral Neuritis

Of special interest was the almost worldwide occurrence, during 1944 and 1945, of a large number of cases of multiple radiculoneuritis. These were reported from the China-Burma-India, Pacific, Mediterranean, and European theaters at about the same time. Almost half were related to faucial or cutaneous diphtheria. In the faucial form, the onset of neuritic symptoms occurred about 3 to 4 weeks after sore throat began. In the cutaneous form, the onset varied from the 23d to the 158th day after appearance of the skin lesions, averaging 70 days. Neuritis symptoms consisted of paralysis of accommodation, paresthesias, and nerve palsies, often progressing to severe paralysis and atrophy of muscles. Recovery was slow. Of special interest was the frequent albuminocytologic dissociation in the spinal fluid, the protein increasing to as high as 300 to 500 mg. percent with little rise in cellular elements. This dissociation often led to the diagnosis of so-called Guillain-Barré syndrome, but when the symptoms and signs were correlated, it became apparent that the condition was diphtheritic, even though it was not always possible to isolate virulent *Corynebacterium diphtheriae* from the infected skin or faucial lesions.

In other cases presenting evidence of infectious radiculoneuritis, with or without albuminocytologic dissociation, the etiology was more obscure,

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[9] The discharge of epileptic soldiers was also given special attention through the military and Red Cross social service groups arranging for a careful "followup" program, often arranging for local physicians' care before they left the hospital, especially when dependent on medication to control seizures. —W. H. E.

[10] During the Korean War, persons with idiopathic epileptic diseases controlled by the usual medication were acceptable for military service. Under current (1965) Army policy, all epileptic disorders are unacceptable for service in peacetime but controlled seizure disorders are acceptable during general mobilization.—A. J. G.

and factors such as malnutrition, fevers, sulfonamides, and various toxic and infective agents were invoked.

Another puzzling type of neuritis seen particularly in the Pacific and Burma areas involved the shoulder girdle, usually on one side. The course was principally initiated by sharp pain for a day or so followed by paralysis and atrophy of the deltoid, spinati, latissimus dorsi, and serratus magnus, and by mild sensory diminution. Recovery was slow and, usually, incomplete. Trauma did not seem to play a role; poliomyelitis was excluded by the presence of sensory changes. Almost all the cases occurred in persons having malaria or dysentery. Atabrine (quinacrine hydrochloride), which was extensively used, was suspected by some as an etiological factor, but its role was never proved. In one of the hospitals in the United States (Station Hospital, Camp Livingston, La.), two soldiers were found to have anesthetic leprosy.

Multiple neuritis of varying severity was frequently seen in repatriated prisoners of war. (See pages 551–552 and 553–554.)

Herniated Nucleus Pulposus

Although MR 1–9 specifically stated that individuals having evidences of herniated nucleus pulposus or a history of operation for this condition were nonacceptable for military service, there were a number of such persons inducted. These inductees, together with personnel who developed the condition incidental to the rigors of service, constituted 6.6 percent of the admissions for neurological disorders (derived from table 60). That this was an important problem with ramifications into professional, administrative, legal, and manpower spheres was early recognized, and the need for all medical officers to be cognizant of these implications prompted the issuance of Circular Letter No. 43, Office of The Surgeon General, on 13 February 1943.

The purpose of this circular letter was to direct the attention of medical officers to the diagnostic and therapeutic problems of herniated nucleus pulposus. It covered the characteristic clinical manifestations of the condition and laid down rules governing myelography. The directive also stressed the line-of-duty status of patients so afflicted and advised that any surgical intervention was the combined problem and responsibility of orthopedic surgeons and neurosurgeons. Emphasis was placed on the inadvisability of performing elective operations for herniated nucleus pulposus antedating induction.[11]

Nevertheless, the problem was ever-present. As close cohesion developed in the centers, most of such cases were admitted on the neurological service where diagnostic studies were carried out. Myelography, using Pantopaque (iophendylate), was usually performed at this time, either by

[11] Circular Letter No. 190, Office of The Surgeon General, U.S. Army, 17 Nov. 1943.

the neurologist or the neurosurgeon, depending on local arrangements. It was generally believed that this procedure should be routinely done, not only to prove the clinical diagnosis but also to provide the surgeon with accurate localization. After roentgenograms were taken, the Pantopaque was aspirated, a not too difficult procedure in experienced hands.

Cases selected for operation were transferred to the neurosurgical service. Those to be treated conservatively were usually placed under orthopedic supervision when the problem was primarily musculoskeletal.

During 1943 and early 1944 when there were urgent demands for the utilization of all available manpower, approximately 43 percent of herniated disk patients were retained on limited-service assignments. Persistent or recurrent symptoms were frequent and led to rehospitalization of many of these patients. It became apparent that, under the stresses of military service, retention of soldiers and officers with herniated nucleus pulposus, whether treated conservatively or surgically, was fraught with uncertainty. After issuance of WD Circular No. 212, on 29 May 1944, prohibiting the return to duty of soldiers without special qualifications who could not do a reasonable day's work, there was a notable increase in the rate of discharge for this condition. This is reflected in table 63, relating to patients admitted for herniated nucleus pulposus in 1943 and their military status as of February 1945. These data indicate that 27 percent were still on duty as of February 1945 (73 percent were separated). (Note the wide differences when these data are differentiated by method of treatment, table 63.)

With the dimunition of personnel requirements on cessation of warfare in Europe and the accumulation of further experience, a final plan of management was embodied in WD Circular No. 209, issued on 13 July 1945. This circular recognized the recurrent symptoms of those returned to some form of duty. Conservative treatment was recommended in all cases not incurred in line of duty, with subsequent separation from the service, except those cases with intractable pain or evidence of neural paralysis. Corrective surgery in such cases could be done with the consent of the patient. In those patients who incurred the condition in line of duty, either conservative or surgical treatment could be performed, depending upon the wishes of the patient. Disposition was to be accomplished under existing directives. The operative treatment of these cases was made the sole responsibility of the neurosurgeon.

Thus, the evolution of the management of herniated nucleus pulposus in the military setting was difficult, trying, and discouraging.

NEUROLOGICAL DISORDERS IN ALLIED REPATRIATES AND JAPANESE PRISONERS OF WAR

The scope of this section is entirely clinical and represents some observations, made by the writer, of the physical and neurological status

TABLE 63.—*Followup study of 520 patients admitted in 1943 for herniated nucleus pulposus and their military status as of February 1945*

Personnel and military status	Total	Method of treatment		
		Excision or laminectomy	Other operations	No operation
Enlisted men:				
Admitted (1943)	450	101	32	317
Status as of February 1945:				
In service	90	47	3	40
Separated:				
Number	360	54	29	277
Percent	80	53	91	87
Officers, male:				
Admitted (1943)	62	33	6	23
Status as of February 1945:				
In service	44	26	2	16
Separated:				
Number	18	7	4	7
Percent	29	21	67	30
Females:				
Admitted (1943)	8	4	----	4
Status as of February 1945:				
In service	5	3	----	2
Separated:				
Number	3	1	----	2
Percent	38	25	----	50
Total personnel:				
Admitted (1943)	520	138	38	344
Status as of February 1945:				
In service	139	76	5	58
Separated:				
Number	381	62	33	286
Percent	73	45	87	83

of some Allied repatriates removed from Japanese prison camps in Japan and China to U.S. Army hospitals in Saipan and the Philippine Islands, and also of Japanese prisoners of war in the Prison Hospital at New Bilibid (Philippine Commonwealth Prison) and the nearby prison stockade after the Japanese surrender.

Allied Repatriates

U.S. military personnel

The first repatriates examined were a group of 75 American troops removed from Japan and hospitalized in Saipan. These troops had been

imprisoned since earliest hostilities in the Pacific; first in the Philippines and, later, in Japan.

Information derived from histories taken from these men was quite similar, with the various presenting clinical disorders having occurred at about the same time in all patients examined.

Diet.—The diet during imprisonment had always been low in calories; dietitian's estimate was from 800 to 2,000 calories, usually about 1,500. Food intake was never adequate from the standpoint of a balanced diet since it was regularly low in proteins, fats, and vitamins, and always very high in starches. The main staple was rice, with yams, leafy vegetables, and oil (coconut). Very little meat or fish was ever contained in the diet, and fruit was rarely obtainable. The diet was the same for everyone and, therefore, especially inadequate for those who had to work and for men of above-average stature. The recovered prisoners stated that generally the larger men had suffered more and, when sick, recovered less frequently than did the men of small stature.

General symptoms.—Chronologically, the earliest disorders described by these troops were progressive severe weight loss, and in about 4 to 6 months, many noted swelling of their feet and ankles. This varied in degree and, at times, disappeared. There was also general lassitude and easy fatigability. In the first year of imprisonment, many noted very sore mouths and bleeding and swollen gums (scurvy); others had painful fissures at the angles of their mouths (riboflavin deficiency). Many, too, described burning sensations of the feet and told how they could barely walk because of pain and burning in soles of their feet. In some, the burning pain of the feet appeared to be an isolated phenomenon; in others, it seemed to be an accompaniment of the prodrome of dry beriberi, since there developed shooting pains and persistent burning in soles of the feet. These shooting pains often ascended to the knees and might also later affect the hands and forearms. There were also visual symptoms; first, a dimness, notably in the evening, and, later, varying degrees of blindness. Night blindness and corneal ulceration were also described as isolated symptoms.

That pellagra was also common was evident from descriptions of sore mouths; swollen, painful, reddened hands and feet or other exposed body surfaces; and, occasionally, mental dullness and impaired memory.

Far more common, however, was the swelling of the feet and ankles during the day, and of the face each morning—a dependent type of edema, which might become quite severe and, additionally, produce a large swelling in the scrotum and abdomen, which was completely incapacitating. With this edema was described a severe frequent nocturia of 12 to 15 times during the night.

The disorders, first described, were always made worse, or at times precipitated, by malaria, dysentery, or intestinal worms, all of which were prevalent in the Pacific Ocean Areas.

These then were the clinical histories of the repatriates, most of whom had, or at the time of examination manifested, symptoms of these disorders and were responding well, for the most part, to a purely supportive regimen of diet and vitamins.

Of particular interest was the fact that many of the repatriated troops, having been edema free and ambulatory, with only minor distress in their feet, before embarking from Japan, developed severe edema, and a few extremities became almost paralytic. This occurred while on warships, en route to Saipan, when the men were permitted to satisfy a voracious appetite during their week at sea; some of these cases subsequently became severe therapeutic problems. Also in the hospital, it was early apparent that these very starved and physically wasted men could not tolerate a full diet; least well did they tolerate large blood transfusions even though some men were very anemic and had low levels of blood protein. Hence, it became the practice to feed the more severely ill patients, calorically, according to weight plus about 15 percent; to give multivitamin capsules; and to reserve small transfusions of blood for only the severest cases of malnutrition. As a rule, the clinical course was good, and in about 10 days, the patients could tolerate a regular diet and gained strength rapidly. All the repatriated troops seen at the hospital in Saipan already had had an improved diet for 3 to 4 weeks before arrival at the hospital, because food had been dropped to them by air after 16 August 1945, and they had been at sea for a week.

Neurological disorders.—Of this group, there were six severe organic neurological cases and two psychiatric problems. The most severe organic case was a soldier, 31 years of age, white, and of average height, who had been in good health before imprisonment. He had lost weight severely in the early months, intermittently had had edema of his ankles, had had sore mouth on one occasion, and then, after about 9 months of captivity, began to have dimness of vision especially at dusk. Shortly thereafter, he noted failing vision in the regular daylight. He also began to have weakness in his feet which shortly developed into burning and shooting pains in his feet and legs. Several months later, he began to have tremor of his head, marked unsteadiness in arms and legs, and lastly, his legs became quite numb and very weak—hands to a lesser extent; also he noted his memory becoming rather poor for daily happenings.

Upon examination of this patient, pronounced emaciation of the body as well as severe atrophy of the extremity muscles was observed. There was a marked head tremor and tremor of arms and hands, the right greater than the left. Nonequilibratory tests were performed in a very ataxic manner, and pronounced intention tremor was present in the finger-to-nose test. There was great weakness in forearm and hand muscles, and a bilateral drop foot was present. All deep tendon reflexes were absent. Plantar irritation produced neither flexion nor extension, and abdominal reflexes

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were not obtained. There was marked sensory loss in the feet (pain, touch, position, and vibration) which feathered out to the knee and, to a lesser extent, was present in the hands. There was pallor of the optic nerve heads, the left more than the right, and bilateral central scotomata of moderately severe degree (he could not read); pupils were sluggish but equal, and the extraocular movements were normal. Mentally, the patient was euphoric, memory for recent events was rather poor, and he complained of an inability to think things through. Otherwise, he was in good contact and cooperative.

Thus, this was a patient with signs very suggestive of a superior polioencephalitis of Wernicke, in addition to a beriberi type of multiple neuritis.

The other organic cases were patients with multiple neuritis of moderate to severe degree, affecting upper and lower extremities, and with central or paracentral scotomata of varying degree. In these men and in others not showing actual visual loss, there was the additional complaint of tiring, burning and watering of the eyes when reading or trying to focus visually for any length of time. This condition quite probably represented an accommodative fatigue due to weakened extraocular muscles in keeping with the general asthenic state. Except for the symptoms of central nervous system involvement noted in the previously described patient, the development of neuritis, with disability, in the other neurological patients was almost identical in time of occurrence.

From the standpoint of treatment, the repatriated prisoners received a high-vitamin, well-balanced diet and showed pronounced improvement relative to malnutrition and general strength. Vision showed some initial increase in acuity, but whether this improvement was due to an alleviation of the vitamin A deficiency is questionable. Further, observation was too short to confirm this improvement; also, it is doubtful that recovery ever occurs from such large scotomata.

Psychiatric symptoms.—The two psychiatric cases were quite dissimilar. One patient was an obvious withdrawn hallucinating schizophrenic who, over a period of 3 weeks, had shown little or no change in behavior although malnutrition was much alleviated. The symptoms of the second came closest to possibly being related to malnutrition and vitamin deficiency. This patient was very undernourished, weak, and apathetic; he answered questions slowly, but correctly; and he showed faint sparks of interest from time to time, and would ask questions. His memory was poor for recent events; he seemed confused and bewildered; and he stated that he could not think well and had lost his mind. With improvement from malnutrition, there was concomitant gradual improvement of this patient's mental state.

Just how much pure psychological disorder was present is difficult to evaluate; however, a certain amount of apathy, "dulling of their senses,"

and bewilderment was present by complaint, in a considerable number of these very malnourished repatriated troops, which fortunately improved after a time under adequate dietary care.

British Commonwealth troops

The second group examined consisted of British Commonwealth repatriates made up of Australian, Canadian, and English troops. Many were survivors from the garrison at Singapore, who were taken to Thailand where, under working conditions of building a railroad through the jungle, they suffered severely from malaria, dysentery, and cholera, with the usual high mortality rate. Subsequently, while being transported to Japan, three-fourths of their number were lost from torpedoing at sea. Other repartriates were of the original very embattled garrison at Hong Kong. In this latter group or camp, although there had been no cholera, there had been a severe epidemic of diphtheria with a high mortality. Altogether, a total of 550 repatriates were examined.

The history of very inadequate diet, weight loss, disease, and hardships in these repatriates was not unlike that of the American prisoners. It was largely a matter of the locale of imprisonment.

Neurological cases.—Of this hospitalized group of 550 men, 10 percent were neurological cases, and approximately, 1 percent were psychiatric cases. In the neurological group, 17 were severe problems, 9 of which clearly involved the spinal cord. Two of the patients with spinal cord diseases, labeled beriberi, had degenerative disorders, predating capture, which were characterized by diplopia, ataxia, and pyramidal tract signs (probably multiple sclerosis). These patients had been in the prison hospital most of the time and, although malnourished, showed no signs of neuritis. The other seven patients with spinal cord conditions exhibited a moderate degree of combined system disease not unlike that seen in pernicious anemia (no anemia was found) with presence of pyramidal tract signs; in addition, there were bilateral central and paracentral scotomata with associated pallor of optic nerve heads and evidences of multiple neuritis in the lower extremities. The picture was a mixed one; the early history was invariably that of a multiple neuritis of beriberi type with spinal cord involvement appearing later in the course of the disease. One patient was almost completely blind, with only a small amount of peripheral vision remaining.

The other eight severe neurological disorders were all advanced cases of multiple neuritis with accompanying central scotomata of varying severity and mild to moderate pallor of the optic nerve heads. These patients gave the history, with little variation, of dimming vision, about 8 months after capture, which was first noted in the evenings. For this symptom, many received vitamin A with prompt improvement. Later,

however, they noted their vision was also impaired in the daylight hours, and about this time, foot pain developed, which progressed to severe degrees with shooting pains in the soles and up the legs. These symptoms varied in severity for months. Gradually, however, vision became permanently impaired; also, as extremity pain subsided, numbness and weakness became more apparent. Two of the patients had anesthesia and analgesia in the legs up to the knees and over the hands and forearms, with lateral foot drop and absent tendon and periosteal reflexes. All could walk with guarded steps, aided by a cane, but several had considerable foot pain.

All the severe neurological patients stated they had much trouble in thinking. They described a sort of "mental blurring" in which they were unable to think quickly, clearly, or completely, or recall recent events with any degree of clarity. This mental state became progressively worse over a period of many months, before release from captivity.

Defects in hearing were not prominent among these repatriates although a few complained of tinnitus. Two of the patients with spinal cord disorders had bilateral nerve deafness of a degree sufficient to make it difficult to obtain a history.

The remaining patients with neurological disorders exhibited varying grades of multiple neuritis. Some had hyperesthesia, hyperalgesia, and pressure pain in the muscles of the calves and feet; others had spots of hypesthesia and hypalgesia; and still others complained of "like bugs crawling" sensations in the extremities which were regaining function. All these patients, at one time or another, had some swelling of the feet, although this was not present at the time of examination.

Generally, a high-caloric, high-vitamin diet promptly alleviated the malnutrition and weakness. Patients with milder disorders showed almost miraculous improvement in the few weeks they were hospitalized (they had also received an improved diet for 3 weeks before arriving at the hospital). Patients with more severe neurological disease showed good general response to food and vitamins, but the basic neurological disorder was little altered during this period of observation (3 weeks), with the exception of the mentally obtunded state from which there was a steady and gratifying improvement.

Psychiatric cases.—All the psychiatric patients in this group showed depression with malnutrition. Two were severely retarded and quite mute, would sit on the side of their beds staring at the floor, and had attempted suicide before repatriation. The other four milder patients were very quiet, expressed ideas of guilt, shame, and worthlessness, but cooperated with ward routine. All these patients showed some improvement in their several weeks in the hospital, although the two more severe patients were removed to the hospital ship because of better psychiatric facilities. All the psychiatic patients gave the appearance of situational depression, and their rather prompt improvement suggested a good ultimate prognosis.

Of the many repatriates in this group, other than the neurological and psychiatric patients, all suffered from malnutrition; in addition, some had malaria, dysentery, or intestinal parasites. Here, again, it was of interest to observe the appearance of edema on heavy initial feeding, its disappearance on a more gradual dietary regimen, and its reappearance in some repatriates who got up and foraged for more food. Many of these patients showed a moderate secondary anemia and a low blood protein; the edema, in these instances, was apparently due to a hypoproteinemia and not to beriberi, as previously regarded. The general outcome of these medical cases was good—malnutrition was alleviated by balanced feeding and the associated diseases were overcome without much difficulty by adequate treatment.

Discussion

In both the American and British Commonwealth repatriates, there was history of a diet deficient in calories and seriously deficient in protein and all water-soluble vitamins; that is, B complex, vitamin C, and, to some extent, the fat-soluble vitamin A. This severe dietary deficiency early became manifest in malnutrition and dependent edema, followed, in only a few months, by the evidences of vitamin deficiency such as sore hypertrophied gums, due to lack of vitamin C; fissured angles of the mouth, due to lack of riboflavin; acute symmetrical dermatitis and sore mouth of pellagra, due to lack of nicotinic acid; and later, manifold symptoms of beriberi neuritis, due to lack of thiamine hydrochloride. Early, too, was the frequency of "burning feet," very probably related to vitamin B deficiency. The prompt response of early visual symptoms to vitamin A administration also warrants its inclusion in the probable overall vitamin deficiencies.

Both the malnutrition and the vitamin deficiency were frequently aggravated by other diseases, by poor living conditions, and by the frequently added burden of physical work. All of these hardships made for a picture of starvation and disease rarely observed and experienced in modern times.

Japanese Prisoners

Following the recapture of Manila and the Japanese surrender, a great number of starved, wounded, and otherwise ill Japanese troops became the responsibility of the U.S. Army Medical Department. These sick and wounded were initially hospitalized at New Bilibid which facilities were soon greatly overtaxed with 4,400 bed patients. Later, they were moved to newly constructed buildings in a nearby prison camp, by which time the hospitalized census rose to over 6,000 patients, the great majority of whom were medical cases. There were, additionally, large numbers of ambulatory ill Japanese prisoners who also showed advanced

grades of malnutrition, many with dependent edema, and who were managed on a regular prisoner status by the military police.

The Japanese soldier, conscripted for the most part from the peasant and fisherman classes, measured an average height of 5 feet 3 inches with a long torso, and short, relatively thick, arms and legs. His discipline was largely one of literal, unthinking, blind obedience. Generally, good cooperation was easily obtained from the Japanese in the care of their sick, who, in turn, seemed very appreciative of whatever was done for them.

There was little stirring under this vast tentage at New Bilibid; cots by the thousands were occupied by these small, wasted men, many with ulcerous, edematous extremities and protuberant bellies. The apathy, stench of the sick, and frequency of death, which was a very public affair, lent a depressing character to an already appalling medical problem. Later, it was possible to improve both management and morale of patients, in particular, and of personnel, in general, by removal to the new hospital.

Interrogation of Japanese Army physicians from both forward and rear echelons yielded the following summary data:

The Japanese soldier's normal diet consisted of three canteen cups of rice, plus meat or fish each day. Yams and other vegetables were regularly available. Some cheese was frequently obtainable. Much of their food was cold-storage type and very adequate. Medicines, too, were always available in ample quantity.

The health of the Japanese soldier was good until late in December 1944 and early January 1945, after which time it declined markedly. The blockade of the Philippines was in effect for a full year before V–J Day, but although their own food supply failed, they were able to "live off the land" until the American invasion drove them into the mountains. Here, they subsisted on leaves, grass, and roots. No meat, fish, rice, or fats of any kind were obtainable. The sick and wounded could not be adequately cared for and many died. Many others became sick and either died of inanition or were too weak to recover from intercurrent illnesses. Medicines too were dissipated, leaving the Japanese without means of combating the then rampant malaria and dysentery.

General symptoms.—The Japanese medical officers pointed out that whereas beriberi was common in Japan, it was rarely accompanied by inanition. Thus, in Japan, three types of beriberi were recognized—dry, wet, and mixed. The dry type usually occurred first; then the mixed appeared. Most cases were of the mixed type when seen by the physicians. However, among Japanese troops in the Philippines, after retreat to the mountains, body wasting was quite severe, as a rule, and it became difficult to differentiate between severe malnutrition and beriberi. Later, both were always associated.

The earliest symptoms of beriberi in this group of Japanese patients were, generally, aches and pains in the body and extremities, fatigue, and, often, some hyperesthesia over the anterolateral surface of the legs

(peroneal nerve distribution) and in the antecubital fossa area, extending up and down in the distribution of the medial and lateral antebrachial cutaneous nerves. This first phase would change into hypesthesia and hypalgesia, often with accompanying tinnitus and mild deafness (vision was never affected). In about 3 to 4 weeks, systemic effects would develop with swelling of the ankles, cardiac enlargement, and often abdominal ascites and fluid in the chest. Many of these soldiers died suddenly of cardiac failure. Some became delirious, and a few became psychotic. Frequently, malaria or dysentery would complicate the conditions of beriberi and malnutrition. Thus, in the Japanese troops, there was a high incidence of morbidity and mortality before capitulation.

Case reports

Direct examination of a great many of these patients (fig. 50) by the author confirmed, in largest part, the clinical observations of the Japanese physicians. The following case records serve to elucidate the most frequently noted neurological findings:

Case 1.—N.S. (fig. 50, right), Japanese, age 35 years. Soldier was in apparent good health and well fed until June 1945 when rations were reduced to half and no meat whatever was available. In mid-June, he began to experience weakness in the

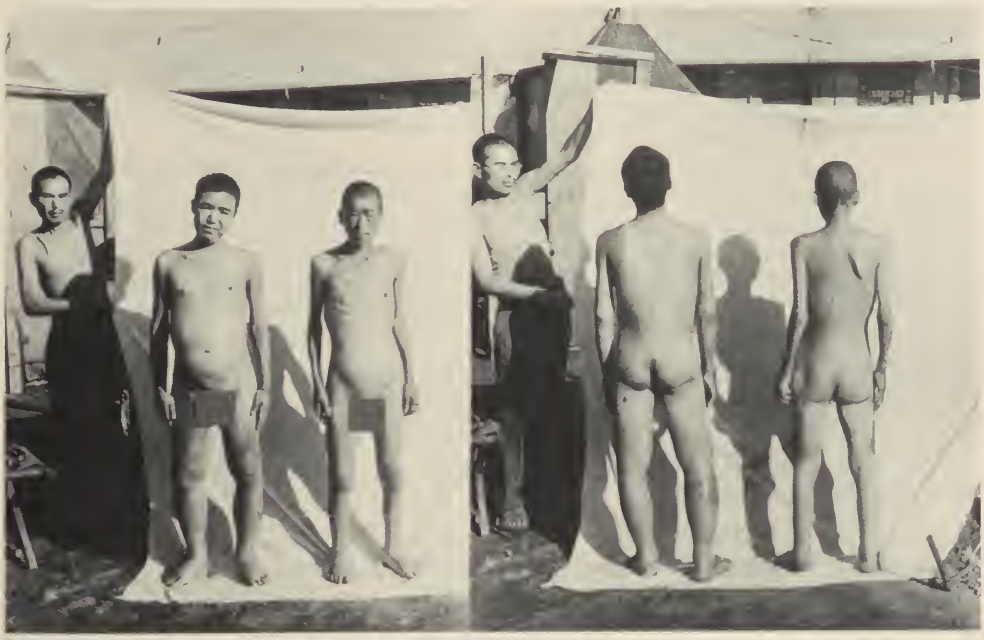

FIGURE 50.—Typical appearance of Japanese prisoner-of-war patients, New Bilibid Prison, 1945. The man with glasses is a Japanese field physician attached to the Japanese troops.

knee joints. Early, in July, his unit retreated to the mountains of northern Luzon. After 2 weeks in the mountains on a very restricted meat-free diet, he noted, for the first time, swelling of his feet and ankles, which progressed upward until it involved the entire lower extremities and scrotum. During the 4 weeks after capture, by the end of August 1945, almost all the edema had cleared but he had developed great weakness of both extremities, with no evidence of malaria or dysentery.

Physically, the patient was very emaciated and pale, with a slight facial edema and pitting edema of both feet. Other findings were: Blood pressure 125/65; pulse rate, 70; heart enlarged slightly to the right; P2 accentuated, all tones distant; liver 1 fingerbreath below costal margin; spleen not palpable; no ascites evident.

Neurologically, the muscles of both lower extremities were atrophic and tender. The patient had difficulty in standing, having to climb up his legs with his hands. Gait was ataxic, and the patient had to watch the ground carefully to maintain balance. The Romberg test was positive, knee jerks were absent and Achilles reflexes much diminished. Hypalgesia was found over the lateral surface of feet, and the second and third toes were bilaterally analgesic. Vibration sense was absent in all toes, perceptible over the foot and normal in the ankles. Upper extremities and cranial nerves were normal. Mentally the patient appeared intact.

Diagnosis.—Malnutrition with beriberi, neuritis, and possible early myelopathy.

Case 2.—M.K., Japanese, age 33 years. Patient was in good health until retreat to mountains in March 1945, when rations were very restricted and no meat was available. In July, he noted much fatigue on slightest exertion and some increased sensitivity on volar surfaces of the arms and the lateral sides of the legs, which shortly changed to numbness in both legs and feet. About 2 weeks later, he began to have swelling of the feet, which progressed upward to involve the scrotum, penis, and face. Walking became very unsteady, and in the 4 weeks before capture, his thinking had become very slow and his hearing, bilaterally diminished with tinnitus. There was no malaria. After capture, the edema cleared, and the patient felt stronger.

Physically, he was emaciated and pale, with no edema. Blood pressure was 100/40; other findings were negative.

Neurologically, the gait was ataxic and guarded, and the Romberg test was mildly positive. There was weakness of dorsal flexors of the feet and of extensors of the leg, with right triceps and ulnar reflexes diminished and all other tendon and periosteal reflexes absent. Abdominal reflexes were present but cremasteric reflexes were absent. Moderate hypalgesia was found on the medial surface of the thighs, in the ilioinguinal nerve distribution (this was strangely quite common), in both common peroneal nerve distributions, and also, to a less extent, over the volar surfaces of both forearms. Vibratory sensation was absent in the toes, diminished on the dorsum of the feet, and very diminished in the fingers of both hands but becoming normal at the wrists. There was moderate bilateral deafness; otherwise, the cranial nerves were normal.

Diagnosis.—Malnutrition with beriberi neuritis and possible early myelopathy.

Case 3.—T.N., Japanese, field grade officer, age 37 years. This patient had had six attacks of malaria in the past 2 years, the most recent being in July 1945. In June 1945, his troops began their retreat to the mountains where the entire food supply was greatly curtailed, until capture late in August 1945. Early in July, the patient noted edema of both feet, which rose slowly to the thighs; then, he began to have a sense of pressure in the chest, with palpitation and dyspnea at night. Shortly after this, he also noted clumsiness in the use of his hands, unsteadiness in walking, ringing in the ears, and "tardiness of thinking."

On physical examination, the patient was found to be well built, with moderate weight loss. The heart was enlarged, both to the right and left. Other findings were: P2 accentuated; pulse rate 72, regular; blood pressure 125/75; spleen palpable 3 finger-breaths below costal margin; and moderate edema of the feet and of the legs to the knees.

Neurologically, he showed an ataxic gait, a moderately positive Romberg, moderate adiadokokinesis, symmetrically diminished deep-tendon reflexes, and diminished sensation to pain in the ilioinguinal, lateral femoral cutaneous, and peroneal nerves with accompanying tenderness in both calf muscles.

Diagnosis.—Beriberi neuritis with probable early myeloencephalopathy; beriberi heart disease; and chronic malaria.

Case 4.—K.T. (fig. 50, left), Japanese, age 50 years, civilian carpenter attached to troops. The patient was well until July 1945, when his unit retreated to the mountains and received half rations and no meat or fish. One month later, only potatoes and a few leafy vegetables constituted the diet. Early in September, he noted swelling of the face and feet, which soon progressed to involve the legs and scrotum. He noticed unsteadiness in walking and weakness in the arms. Shortly before surrender in the hills, late in September 1945, he had a severe diarrhea with accompanying severe weight loss.

Physically, the patient was emaciated, pale, and weak. Edema was severe in the legs and scrotum, with abdominal ascities present. Heart was enlarged both to the right and left, sounds very distant; pulse rate, 75, regular; and blood pressure 110/65; liver enlarged slightly; and spleen not palpable.

Neurologically, his station and gait were normal. The deep tendon reflexes were active and equal. Muscles of the calves and feet were tender. There was a marked hyperesthesia and hyperalgesia over both feet and legs to the knees, especially over the distribution of the peroneal nerves, and also a marked hypalgesia in the ilioinguinal nerve distribution. No changes were noted in the upper extremities or cranial nerves.

Diagnosis.—Malnutrition with beriberi neuritis and beriberi heart disease.

Case 5.—S.T., Japanese, age 26 years; prior health was good. This patient had a severe attack of malaria early in July 1945, and then with his unit retreated into the mountains late in July. The diet consisted of potatoes and vegetables in sufficient quantities, small amounts of rice, but no meats, fish, or oils. In mid-September, he first noted some numbness of the left foot and lateral side of the left leg and, about the same time, the sudden appearance of swelling of the feet, which progressed rapidly to involve both legs and the scrotum.

Physically, the soldier was well built and in a fair state of nutrition. Heart was enlarged to both sides; P2 accentuated; spleen palpable 3 fingerbreaths below costal margin; and moderate pitting edema of both feet and tibias.

Neurologically, he was entirely normal except for hypalgesia over the dorsum of the feet and over the anterolateral surface of the legs, more on the left side than on the right.

Diagnosis.—Beriberi heart disease; early beriberi neuritis and chronic malaria.[12]

From the standpoint of treatment, the Japanese patients received a moderately well balanced diet of about 1,200 to 1,500 calories with multi-

[12] Although the cases presented here exhibit similarities, there are finer differences which should be noted. These variations in the manifestations of nutritional deficiencies demonstrate the need for thorough neurological examinations.—W. H. E.

vitamin capsules and, occasionally, the addition of 10 mg. of thiamin chloride each day. Patients with malaria and any other disease received appropriate therapy. Response to treatment was uniformly good, except for some of the patients with cardiac disease, many of whom died very suddenly.

As soon as these patients were ambulatory, edema free, and gaining weight, they were transferred to the regular prison stockade and maintained on a regular prisoner regimen.

Dependents

There was, additionally, a group of dependents of the Japanese soldiers —100 wives, 35 infants, and a few older children (fig. 51). Malnutrition of moderate to very severe grade was present in all. The nursing infants were cachetic and had obvious vitamin deficiencies, consisting of infantile beriberi, scurvy, and especially cheilosis. Mortality in these infants was great; the majority died in a few weeks' time. The older children behaved

FIGURE 51.—Japanese nurse with dependent children having typical appearance of malnutrition. New Bilibid Prison, September–October 1945.

nutritionally like the adults, and many exhibited a gradual improvement, as did the majority of the women, on an improved dietary regimen.

Discussion

Among the Japanese examined, acute starvation was noted, which could have been regarded as borderline, from the standpoint of vitamin adequacy, occurring not only in the Philippines but also in their homeland. The picture was regularly one of severe malnutrition with evidence of hypoproteinemia and varying grades of B complex and vitamin C deficiency. This particular group was again additionally ravaged by the usual diseases so prevalent in the Philippines; that is, malaria and dysentery. Specific diagnoses were often difficult to establish because of the many mixed conditions and, to no little extent, because of the great paucity of laboratory facilities available at that time in the prison hospital.

One limited study showed clearly a high incidence of moderate to severe degrees of secondary anemia and low plasma protein, often well below the critical level for edema.

Neurologically, there was noted ataxia, tinnitus, mild deafness, and a regular selective impairment of certain peripheral nerves (peroneal, antebrachial, cutaneous, ilioinguinal, and radial) which occurred with great frequency. However, aside from complaints of slight blurring in a few cases, no visual symptoms were encountered and no scotomata evidenced in complaint or examination, nor were there any extraocular palsies.

Transfusions were given in many instances, but here again, the larger transfusions resulted in the sudden death of some patients, and thus smaller transfusions were utilized. Vitamins in the form of multivitamin capsules were regularly administered. The diet was never excessive, so that overfeeding was not a problem.

SUMMARY

Lessons have been learned during World War II with regard to the basic organization and utilization of medical specialists. In the light of this experience, the following remarks would seem pertinent:

In the event of another national emergency, it would appear imperative that a highly competent neurologist be immediately assigned to the Office of The Surgeon General. His duties would encompass prompt establishment of policies relating to the recognition and management of all neurological disorders in the Army and to the coordination of such policies with those of other professional and administrative branches.

Procurement and assignment of neurological specialists should be based upon an established need and their utilization as neurologists assured. Since a separate military occupational specialty number has been

adopted for these specialists, it would obviate much of the difficulty previously experienced in identifying such personnel.

Experience has taught that centers specializing in the different medical and surgical subspecialties are feasible, economical of personnel and material, and of particular benefit to the patient. Neurological-neurosurgical centers, modeled after those used in the Zone of Interior, during World War II, should be designated as soon as practicable and placed in geographically strategic locations in the United States. Well staffed and equipped, these centers would also institute courses of training in neurology for medical officers to be assigned to general and station hospitals, elsewhere, and would also serve as a place to indoctrinate militarily other incoming specialists in neurology.

Key professional personnel staffing these centers should be, as nearly as possible, permanently assigned, so that genuine continuity of professional management and scientific observation over an extended period of time can be made possible.

Theaters of operations, in the light of experience in this war, should have neurological-neurosurgical centers comparable to those established in the United States, located in base medical installations, to support the ongoing military operations. Neurologists in these centers would be available for consultation to any satellite medical installations. Further, it is believed that each major theater would profit by the assignment of a neurological consultant who could coordinate all phases of neurology in both rear and forward echelons within the theater.

The problem of management of trauma to the head, spinal cord, and peripheral nerves has exemplified the necessity for close liaison among neurosurgery, neurology, and psychiatry. All three must be intimately related, and all should develop better basic knowledge in the related specialty.

In regard to neurological disorders which were found among both the Allied repatriates and the Japanese prisoners of war, the following findings are submitted:

1. All Allied repatriates examined showed advanced chronic malnutrition and vitamin deficiency resulting from diet seriously deficient in proteins, fats, and all water-soluble vitamins, including to some extent the fat-soluble vitamin A.

2. The edema present appeared more often related to hypoproteinemia than vitamin deficiency per se.

3. Whereas vitamin deficiency was very important in the production of neurological disorders, there can be little question that deficient nutritional aspects, especially as regards proteins and fats, were also important.

4. The health of many repatriates was also gravely impaired by such intercurrent diseases as malaria, dysentery, and intestinal parasites; some also by cholera and diphtheria.

5. The Japanese prisoners demonstrated en masse the effect of acute severe starvation which occurred while they were hiding in the mountains, where they had few food supplies and were unable to forage effectively. Their diet, at this time, thus was deficient in protein, fats, and vitamins.

6. Both the neurological and systemic aspects of beriberi were common among the Japanese, along with severe malnutrition. Additional effects of the very prevalent malaria, dysentery, and intestinal parasites were frequently noted.

7. Psychoses were singularly few in both Allied repatriates and Japanese prisoners of war.

8. Treatment of all cases, both Allied and Japanese, resolved itself about a supportive program of a high-protein and otherwise well-balanced diet, multivitamins, and, in some, whole blood transfusions. Treatment of intercurrent disease was accorded as indicated.

9. The systemic aspects of starvation responded excellently to treatment, as a rule—the neuritic element improved completely, if mild, and more slowly if severe. The myelopathy noted in Allied cases was of long standing and showed little change while under observation. The myelopathy evidenced in the Japanese was at the very early stage; it improved along with the improvement of the general neuritic pathology. Although the gross aspects of vision often improved, there was little or no change noted from the larger scotomata. Since scotomata represent lesions in the central nervous system, little improvement may be anticipated.

Part IV

SUPPORTING SERVICES AND PERSONNEL

CHAPTER XIX

Clinical Psychology

Morton A. Seidenfeld, Ph. D.

HISTORICAL NOTE

Just where or under what circumstances the use of psychological services first became necessary in military action is not known. Certainly, commanders such as Wellington and Bonaparte must have recognized the psychological elements that made men fight, that maintained their loyalty, and that kept them from deserting.

In the Hitopadesa ("Book of Good Counsel"), written about 500 A.D., in India, it is said: "A small army consisting of chosen troops is far better than a vast body chiefly composed of rabble; for when the bad give way, the good are inevitably broken in consequence."

Early recognition of the importance of army leadership in ancient times led to such statements as: "The leaders of this people cause them to err; and they that are led of them are destroyed." (Isaiah ix: 16, c 75 A.D.) And witness Tacitus who said: "Reason and judgment are the qualities of a leader." (History III c 105 A.D.) And the Latin proverb: "An army of stags led by a lion would be better than an army of lions led by a stag."

Thomas Jefferson, writing to James Monroe (1813), said: "We must train and classify the whole of our male citizens and make military instruction a regular part of our collegiate education. We can never be safe till this is done."

Henry Knyvett, in "The Defense of Realme," wrote in 1596: "Because such as are to become men of war are to be of perfect age most apt for all manner of services and best able to support and endure the infinite toils and continual hazards of wars, I have chosen all between the age of eighteen and fifty to become trained soldiers."

With all due respect for psychological factors that influenced military performance, it was not until the professional psychologist's role in selection and utilization of personnel was appreciated that consideration was given to regular employment of psychology by the Army.

Shortly before World War I, the state of the psychological arts was such as to permit adoption by the Military Establishment. The demand for the rapid induction and training of men associated with the entry of the United States into World War I made it apparent that some suitable means of selection and placement was essential.

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The history of the psychological services in World War I is recounted in the two excellent volumes entitled "The Personnel System of the United States Army." This excellent history will not be reviewed here; suffice it to say that, on 6 April 1917, when Congress declared war on Germany, the U.S. Army of 190,000 grew, in 20 months, to a force of 3,665,000.[1]

Much of the organizational structure and function ultimately evolved by the Committee on Classification of Personnel became the pattern for personnel practice in World War II. A word regarding the relations of the committee and the Medical Department that prevailed in 1918 is pertinent to this present discussion.

Personnel procedures and the Medical Department.—In World War I, as later in World War II, a moderately close working relationship existed between the Army personnel organization and the Medical Department. Physical status must influence vocational assignment much as psychological characteristics do. The weight of emphasis throughout World War I was placed on proper job assignment and the attainment of effective on-the-job performance from each able-bodied person in the service. The maintenance of the individual's mental health and the emphasis on the healthy personality was not fully appreciated in the Military Establishment until World War II.

It is significant to note that Maj. Robert M. Yerkes, SnC (Sanitary Corps), was the first commissioned psychologist in the Army. He remained at the head of the Division of Psychology in the SGO (Surgeon General's Office) during the entire World War I period. In civilian life, Dr. Yerkes was one of the leading scholars in the field of animal psychology and pioneered many of the great advances leading to modern clinical psychology. Similarly, Maj. Louis M. Terman, SnC,[2] was responsible for the development and standardization of the Stanford revision of the Binet-Simon Intelligence Test. Majs. C. S. Yoakum and Terman prepared chapter X, "Intelligence Ratings," in the "Personnel Manual" [3] which clearly indicated how intelligence when properly evaluated could be used in the assignment of men. Obviously, with the clinical program in the hands of men of such stature, it was destined to make many fundamental contributions to the Army program.

Rehabilitation.—By late 1918, psychological personnel were working in collaboration with the Division of Physical Reconstruction, SGO, in the restoration to duty of temporarily and permanently disabled soldiers. When duty restoration was not completely feasible, these soldiers were restored sufficiently to return to a satisfactory social and vocational role in civilian life. Thus, psychology's role in rehabilitation became estab-

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[1] Committee on Classification of Personnel in the Army: The Personnel System of the United States Army: Volume I. History of the Personnel System. Washington, D.C., 1919, p. 28.

[2] (1) Terman, L. M.: Tests of General Intelligence. Psychol. Bull. 15: 160–167, 1918. (2) Terman, L. M.: The Use of Intelligence Tests in the Army. Psychol. Bull. 15: 177–187, 1918.

[3] Committee on Classification of Personnel in the Army: The Personnel System of the United States Army: Volume II. Personnel Manual, 1919.

lished. This role was extended in World War II and has become a major area of clinical interest.

DEVELOPMENT OF CLINICAL PSYCHOLOGY PROGRAM IN WORLD WAR II

Initial Phase

Clinical psychologists were present in Army installations almost from the beginning of the mobilization period which preceded World War II. The earliest reception centers of the Army, which began operation in the late fall of 1940, frequently had such personnel assigned. They worked in the classification program and were also responsible for orienting officers and enlisted men to basic psychological concepts. From the start, the value of the person inducted into the service was emphasized. Emphasis was placed on the need for doing something to aid the inductee in assignment, in personal adjustment, and in learning to be a soldier.

The specific utilization of clinical psychologists, as such, in the Army during World War II, occurred in the spring of 1942. Six clinical psychologists were directly commissioned as first lieutenants in the Sanitary Corps at the request of Lt. Col. (later Col.) Patrick S. Madigan, MC, then chief of the Neuropsychiatry Branch (later the Neuropsychiatry Consultants Division), Professional Service Division, SGO. They were assigned to six of the permanent named general hospitals for duty with the neuropsychiatric sections, as follows: Michael Dunn, to Darnall General Hospital, Danville, Ky.; Robert M. Hughes, to Lawson General Hospital, Atlanta, Ga.; James W. Layman, to Walter Reed General Hospital, Washington, D.C.; William C. Murphy, to Letterman General Hospital, San Francisco, Calif.; Lawrence I. O'Kelly, to Fitzsimons General Hospital, Denver, Colo.; and L. Grant Tennies, to McCloskey General Hospital, Temple, Tex.

The assignment of clinical psychologists was regarded as an experiment, undertaken at the instigation of Dr. Winfred Overholser and Dr. Franklin G. Ebaugh, members of the Medical Section, and of Dr. Yerkes and Dr. Leonard Carmichael of the Psychology and Anthropology Section of the National Research Council.[4] The National Roster of Scientific and Specialized Personnel had submitted a list of qualified psychologists to the Surgeon General's Office in 1941,[5] but no action had been taken until Colonel Madigan's request in 1942.

The utilization of clinical psychologists had adequate precedence. In World War I, the Division of Psychology was composed of psychologists,

[4] Minutes, Meeting, Sub-Committee on Psychiatry, National Research Council, 6 Mar. 1942. At this meeting, Dr. Overholser stated that clinical psychologists were not being used and recommended that further action be taken.

[5] Layman, J. W.: Utilization of Clinical Psychologists in the General Hospitals of the Army. Psychol. Bull. 40: 212–216, 1943.

then commissioned in the Sanitary Corps, working under the direction of The Surgeon General. During the intervening years, provision had been made for psychologists who desired commissions in the Officers' Reserve Corps to obtain appointments in the Sanitary Corps.

There was virtually no provision for the training of psychologists in the Reserve Corps before World War II. Most reservists, trained as psychologists, preferred that their Reserve commissions be granted in branches and services of the Army other than the Sanitary Corps, for this Corps' prime interest was generally directed to professional services other than psychology. Even in the immediate prewar days, when planning for the use of psychologists was underway, most psychologists were strongly opposed to assignment in the Sanitary Corps where they feared their special professional skills might be minimized. As a result of this, many psychologists, both in the Reserve and those called from civilian life, were assigned to the Adjutant General's Department. This was not surprising since their initial assignments were to develop suitable means of carrying out the programs of induction, classification, and assignment of the hundreds of thousands of newly inducted personnel.

Extension of Clinical Psychology Services

Colonel Madigan was succeeded by Col. Roy D. Halloran, MC, in August 1942. In December 1942, Colonel Halloran investigated the desirability of extending the psychological services.[6] He sent inquiries to the hospitals, then using psychologists, regarding the psychologist's role in neuropsychiatric sections. The supervising psychiatrists reported that psychologists were engaged in a variety of important duties. The consensus indicated that they were an extremely useful adjunct to psychiatric practice in the military setting.[7]

Colonel Halloran was succeeded by Col. (later Brig. Gen.) William C. Menninger, MC, in December 1943. Formal talks between the Surgeon General's Office and the Adjutant General's Office led to the appointment of a liaison officer between these two agencies. Since most of the psychologists in the Army were in the Adjutant General's Department, this was an extremely necessary step in securing psychological services for Army hospitals. Lt. Col. Morton A. Seidenfeld was called upon to assume this liaison position. He established close relationship between the Neuropsychiatry Branch, SGO, and the Classification and Replacement Branch, AGO (Adjutant General's Office), to which he was assigned.

In late December 1943, Colonel Seidenfeld prepared a standing operating procedure which clarified the liaison role of his office and which indicated the initial special assignments of psychologists. Frequent dis-

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[6] Letter, Col. Roy D. Halloran, MC, Surgeon General's Office, to Dr. Steuart H. Britt, Executive Director, Office of Psychological Personnel, National Research Council, 21 Dec. 1942, subject: Psychologists.

[7] See footnote 5, p. 569.

cussions between Colonels Menninger and Seidenfeld finally brought concrete results on the matter of assignments.

On 23 May 1944, the Surgeon General's Office,[8] in a letter to the Commanding General, ASF (Army Service Forces), relative to a program for establishing the assignment of clinical psychologists to general and large station hospitals, pointed out as follows:

> For a considerable period, this office has been attempting to obtain the services of clinical psychologists in general and larger station hospitals. * * * where these officers have been employed, they have been invaluable assistants to the hard pressed neuropsychiatrists. * * * The services of these clinical psychologists are needed more than ever before because of the increasing scarcity of neuropsychiatrists. Their assignment would permit a more adequate distribution of these specialized medical officers. It is the opinion of this office that they should be procured, commissioned, and assigned to duty through a special section of clinical psychology under the direction of the Classification and Replacement Branch of the Adjutant General's Office, and that the * * * psychologists now commissioned in the Sanitary Corps should be reassigned to the Adjutant General's Department for the following reasons:
>
> The Classification and Replacement Branch of the Adjutant General's Office already has an administrative structure designed and adequately functioning to determine qualifications and select all psychologists * * *.
>
> The present location of clinical psychologists among a varied group of technicians in the Sanitary Corps does not provide adequate supervision.
>
> * * * * * * *
>
> It is believed that as a fundamental consideration, psychology is so specialized that all psychologists in the Army should be grouped in one service, namely: Classification and Replacement Branch of the Adjutant General's Office.

Recognizing its importance, The Adjutant General designated Colonel Seidenfeld as Chief Clinical Psychologist, responsible for the implementation of this procurement and utilization program.

Following this initiation of the program, the Director of Personnel, ASF, stated: "It is recommended that this program be approved; that The Adjutant General be given procurement authority for 175 officers who meet the requirements * * * to be appointed in the grade of First and Second Lieutenant."[9]

On 23 June 1944, the Secretary of War directed that a WD (War Department) circular be published informing commanders that clinical psychologists commissioned in the Adjutant General's Department would be made available for assignment to the neuropsychiatric section of certain hospitals, defining their duties, and directing that requisitions be forwarded through the necessary channels to the Adjutant General's Office. The circular was prepared and issued on 1 July 1944 as WD Circular No. 270.

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[8] Letter, Lt. Col. Robert J. Carpenter, MC, Executive Officer, Surgeon General's Office, to the Commanding General, Army Service Forces, Washington, D.C., 23 May 1944, subject: Clinical Psychologists,

[9] Memorandum, Director of Personnel, ASF, for Assistant Chief of Staff, G–1, War Department General Staff, 14 June 1944, subject: Procurement and Utilization of Clinical Psychologists.

PROCUREMENT

Survey of Eligible Personnel

With official approval of the War Department, in July 1944, procurement of personnel to fill the anticipated requisitions was given top priority. A preliminary survey revealed that few clinical psychologists with the necessary educational qualifications and experience were available. Most of them were already in the service or were serving in vital civilian capacities. A survey of enlisted and officer personnel of the Army revealed that the comparatively small immediate requirement could be met from the resources within the Army. Since War Department policy indicated that direct commissioning of civilians was to be curtailed, it was decided that officer personnel to meet the requirements of the program could be obtained by reassignment or by training enlisted personnel, with subsequent promotion to officer status.

To prepare for the anticipated needs, several activities were promptly initiated. A survey of the available talent within the Army was made, standards for the granting of a commission were established, and procedures for processing applications were instituted.

War Department policy directed that direct commissioning from civil life or from enlisted ranks was not to take place until all existing officers with suitable skills had been considered. Accordingly, a survey was made of the records of all officers on duty to determine those qualified for assignment as clinical psychologists in accordance with established requirements. This survey was conducted by the Classification and Replacement Branch, AGO, and completed on 24 July 1944.

Reassignment of Qualified Officer Personnel

From the total records reviewed, 41 field grade and 309 company grade officers were found to be qualified as clinical psychologists. As field grade officers were not eligible for assignment to this program and as 66 of the company grade officers were already assigned as clinical psychologists at station and general hospitals, there remained 243 officers to be considered. Of this group, it was found (1) that 164 were already in key positions where their psychological experience was essential, and (2) that the remaining 79 were assigned to various ASF, AGF (Army Ground Forces), and AAF (Army Air Forces) installations where their psychological training was reported as being essential. Contact with the using agencies involved, however, revealed that about 20 percent of these officers could be transferred to clinical work.[10]

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[10] Letter, The Adjutant General, to Director, Military Personnel Division, ASF, 5 Aug. 1944, subject: Assignment of Clinical Psychologists.

On 14 August 1944, the Director, Military Personnel Division, ASF, in a memorandum to The Adjutant General, indicated, as follows:

> * * * the War Department directed that priority be given the transfer of officers qualified as clinical psychologists. In view of this directive, it is believed that more than 20 percent of the qualified officers should be made available for reassignment to fill requisitions submitted in accordance with WD Circular No. 270, dated 1 July 1944. In order to insure compliance with War Department instructions, it is desired that the availability of all clinical psychologists be determined. Cases of those officers who are not being currently utilized as clinical psychologists, on whom a nonconcurrence is received, will be referred to this office, with full details regarding present duties and qualifications for appropriate disposition.[11]

This memorandum from the Military Personnel Division made possible the reassignment of these well-qualified officers. Occasionally, an injustice may have been done when the arbitrary rulings of the Military Personnel Division transferred an officer from an assignment in which he was highly qualified. This, however, happened in but very few instances, and the gains from such reassignment clearly overshadowed any harmful results.

The resultant transfers of officers to positions as clinical psychologists eventually brought to the program 130 officer personnel whose psychological competence had not been adequately used by the Army.[12]

It was soon found that reassignment of officers with psychological experience could in no way adequately meet the requirements of the program. This was evidenced by the increasing number of requisitions received by the Classification and Replacement Branch from the field during the summer of 1944 as a result of the publication of WD Circular No. 270.

Enlisted Personnel Source

As early as 3 August 1944, the Office of the Chief Clinical Psychologist had requisitions from all service commands, calling for a total of 213 psychologists. On the strength of this need, The Adjutant General requested the Director, Military Personnel Division, to authorize procurement of an additional 130 clinical psychologists, by direct appointment as second lieutenants, AUS (Army of the United States), from among "enlisted men in the Army who had the proper professional and military qualifications." [13] This and succeeding authorizations for procurement eventually gave the program an allotment of 346 to be filled by direct commissioning from the enlisted ranks.[14] Of these, 35 were allotted to the Army Air Forces and 6 to the Office of Strategic Services, leaving a balance of 305 for ASF

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[11] Memorandum, Dirctor, Military Personnel Division, ASF, for The Adjutant General (Attn: Classification and Replacement Branch), 14 Aug. 1944, subject: Assignment of Clinical Psychologists.

[12] Memorandum, Lt. Col. Morton A. Seidenfeld, for Lt. Col. Malcolm J. Farrell, MC, Surgeon General's Office, 26 May 1945, subject: Report on Clinical Psychologist Program.

[13] See footnote 10, p. 572.

[14] Memorandum, Director, Military Personnel Division, AGO, for The Adjutant General, 12 July 1945, subject: Procurement Objective for the Appointment in the Army of the United States of Clinical Psychologists.

medical installations in the Zone of Interior and overseas. By the end of July 1945, 250 of the 346 total number allocated had been secured.

Qualifications established

Contact was made with the Officer Procurement Service, ASF, and an agreement was reached regarding the minimal qualifications that would be considered acceptable in enlisted applicants for commissions as clinical psychologists. These were published in WD Circular No. 392, issued on 2 October 1944. The qualifications of the clinical psychologist were based in large part upon the standards established by the American Psychological Association and the then existing American Association for Applied Psychology. At no time was it found necessary to utilize personnel who fell below the minimal standards of both official professional organizations.

The minimum educational standards, as set forth in WD Circular No. 392, were as follows:

> * * * a bachelor's degree in psychology, educational psychology, industrial psychology, or sociology. A master's or doctor's degree, or the equivalent in academic credits, in one of these fields is desirable.

Concern, however, was not merely with the academic training. Thus: "These men will be selected from among officers and men capable of interpreting clinical findings in the light of total personality structure and who make use of this knowledge in diagnosis." [15]

Military experience and a knowledge of military life were considered important "but may be weighted less heavily when the professional background justified such action." [16]

Elsewhere, Seidenfeld had said:

> It is apparent to all who have had the task of locating clinical psychologists * * * there are comparatively few who received the kind of training during their academic periods to justify the assumption of adequate qualifications for the assignment. * * * The deficiencies in training have made it necessary * * * to place a premium upon the experience obtained after leaving college. As a result, oftentimes "clinical" must be interpreted as work experience obtained in any environment with individuals on whom psychological judgments must be made * * *. Thus, psychological work done in penal institutions, industrial establishments, social service activities, and the like, are given favorable consideration as well as that done in medical institutions.

In order to secure personnel capable of carrying on this professional role and flexible enough to fit their varied experience into an oftentimes completely new frame of reference, selection was of the utmost importance. To make this possible—

> * * * in the Army, a board [Clinical Psychologist Officers Selection Board] of qualified military personnel sifted each application with great care. Evaluation was based upon breadth of professional experience; evidence of ability to interpret and present interpretations of data gained from psychological examinations; freedom from

[15] Seidenfeld, M. A.: Clinical Psychology in Army Hospitals. Psychol. Bull. 41: 510–514, 1944.
[16] *Ibid.*

rigidity in approach to problems, as well as more orthodox criteria such as academic degrees, age, and other formal elements in the application blank.[17]

Processing of applications

Applications were processed according to the following plan: Interested enlisted men, of the opinion that they met the standards of WD Circular No. 392, submitted their applications in accordance with the regulations (WD Circular No. 363, 7 September 1944) governing all initial appointments in the Army of the United States other than by officer candidate schools. Applications were then reviewed by the Chief Clinical Psychologist and his staff. If an applicant appeared to meet minimum requirements, a "request for processing of applicant" was submitted to the Officer Procurement Service, ASF, and the application was processed. A local board of officers interviewed the applicant; then a report of its proceedings, together with the applicant's medical record and proof of citizenship, was forwarded to the Officer Procurement Service and the Office of the Chief Clinical Psychologist. This process usually required from 2 to 3 weeks.

Clinical Psychologist Officers Selection Board.—With completed papers at hand, the applicant was then considered by the Clinical Psychologist Officers Selection Board,[18] Classification and Replacement Branch, established by the chief of that branch. This board consisted of the chief of the Classification and Replacement Branch (Col. George R. Evans), Dr. Walter V. Bingham, and the Chief Clinical Psychologist (Colonel Seidenfeld), or their respective alternates.

Following the action of this board, cases "disapproved" were placed in file for later review if the applicant had a deficiency that could be overcome merely by spending more time "on the job" as an enlisted man. If an applicant was deficient in fundamental training, the papers were returned with appropriate notation "applicant does not meet standards" and a request that he be so informed.

Applications passed by the board were returned to the Officer Procurement Service through channels, accompanied by Form OPS–3, "Appointment Request," under the signature of the Director, Operations and Training Division, AGO. When the applicant was under the age of 30 and was found to possess superior qualifications for appointment, the application was accompanied by a request for a waiver of age standards.

Approved papers were processed through the War Department Personnel Board and the Assistant Chief of Staff, G–1 (personnel), when an age waiver was needed. Upon approval of these agencies, the applicant was appointed. The first officer thus processed and appointed to a direct

[17] Seidenfeld, M. A.: Psychological Services for the Individual in the Armed Forces. J. Clin. Psychol. 1: 93–98, 1945.

[18] Memorandum, Col. A. P. Sullivan, AGD, Director, Operations and Training Division, AGO, for The Adjutant General, 17 Oct. 1944, subject: Action of Clinical Psychologist Officers Selection Board.

commission was 2d Lt. Max L. Hutt, who reported to active duty as an officer on 18 September 1944.

Factors Influencing Procurement

A number of factors involved in the procurement of personnel for this program are of interest and importance. Basically, procurement was strictly dependent upon the number of requisitions received for psychological personnel from the field. In some instances, service commands were reluctant to submit requests for needed clinical psychologists because additional personnel would increase the actual number of officers above their authorized allotment. To eliminate this problem, the Director, Military Personnel Division, stated:

> It is desired that The Surgeon General be informed that in the event service command personnel authorizations are inadequate to provide for the clinical psychologist requirement, consideration will be given requests submitted by the service commands concerned for necessary increases.[19]

Further, the original procurement authority assumed that all psychologists secured under this program would be assigned only to station and general hospitals within the continental limits of the United States. However, requests for clinical psychologists were received from many other installations and agencies, such as numbered general hospitals preparing for movement overseas, elements of the Army Air Forces, and the Office of Strategic Services. As a result, the original circular (WD Circular No. 270) was revised and issued as WD Circular No. 71, 6 March 1945. This revision officially established the services of clinical psychologists in consultation services (mental hygiene units) of training centers, disciplinary barracks, rehabilitation centers and regional and convalescent hospitals. These increased uses authorized for clinical psychologists resulted in the increased procurement authorizations previously noted (p. 573).

WAC.—Until March 1945, personnel of the WAC (Women's Army Corps) could only be commissioned through officer candidate schools. Quotas for these schools were limited, and as the graduates were used for comparatively general purpose assignments, special skills and talent among the enlisted women were often overlooked. This deficiency was remedied by WD Circular No. 77, issued on 10 March 1945, enabling all enlisted women to apply for commission under specific procurement objectives which included clinical psychology. As a result, five enlisted women were commissioned, in the Adjutant General's Department, as clinical psychologists.

Prejudice.—There was one unfortunate facet to the procurement problem. As has been noted, procurement of clinical psychologists depended

[19] See footnote 11, p. 573.

entirely upon the number and type of requisitions received. A number of well-qualified Negro psychologists applied for commission under this program, but only one was commissioned. For a long time, he languished in an officers' pool, his talents unused, for there were no suitable vacancies for Negro personnel as clinical psychologists. Although a distinction was made between white and Negro operating personnel of hospitals, no such discrimination was made among the patients. The need for clinical psychologists was evident, but prejudice, rationalized by the administrative difficulties which commanders felt would arise with the assignment of Negro personnel to their hospitals, prevented adequate use of this source of available talent.

Results

In general, the procurement phase of the program worked well. Reports upon the men selected for commissioning as clinical psychologists were more than satisfactory.[20] However, there is little doubt that the results of procurement would have been better if the applicant had been personally interviewed by a professional board which could have more thoroughly explored the person's qualifications.[21] This feeling was echoed by the War Department Personnel Audit Team, emphasizing that paper qualifications did not show personality traits which were of paramount importance in this program.

It is most unfortunate that clinical psychology, in spite of its significant contributions, always began its program separated from its normal function with the physician and, most especially, with the psychiatrist. It is to be hoped that in the future such personnel will, from the beginning, work in close relationship with psychiatry. As Menninger[22] has so well described the situation:

> The clinical psychologists proved their value to Army psychiatry * * * their commission in the Adjutant General's Department was a handicap because it did not identify them with medicine. Even after their transfer to the Medical Administrative Corps, they occasionally were assigned to nonpsychologic duties by * * * commanding officers [too lacking in perspective or knowledge to appreciate the value of their psychological skills]. * * * It is to be hoped that the War Department does not discard the present system as it did after World War I.

Perhaps this is too much to hope for since an adequate program for reservist training for psychologists has not been established.

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[20] Report, War Department Personnel Audit Team, 5 May 1945.

[21] Opinion of Lt. Col. Morton A. Seidenfeld, Chief Clinical Psychologist, Classification and Replacement Branch, AGO.

[22] Menninger, William C.: Psychiatry in a Troubled World. Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 245.

PROFESSIONAL TRAINING

Planning

It was deemed highly desirable that all commissioned officers in the Army of the United States possess a certain amount of basic military information. Also, enlisted men who were to receive direct commissions as clinical psychologists required a course of training to obtain necessary knowledge of military subjects and proper orientation in the Army clinical psychology practice.

Colonel Seidenfeld [23] outlined a plan to conduct such training at each of five hospital centers and suggested that a total of 25 officers and 50 enlisted men be trained each month. He also suggested that the training course be repeated as many times as necessary to supply the required number of personnel.

This matter was held in abeyance for several weeks pending the actual granting of the authority to procure the necessary instructors to staff the proposed training program. As soon as authorization had been assured, definite plans for establishing a training course were put into operation. During the interim, outlines of protracted courses had been written by Colonel Seidenfeld and Capt. Jon Eisenson, assistant to the Chief Clinical Psychologist. Capt. Clement H. Sievers was assigned to the Classification and Replacement Branch on temporary duty to assist in preparing the final form of the program of instruction.

On 25 August 1944, the Chief, Classification and Replacement Branch, AGO, in a letter to the Chief, Troops Branch, AGO, indicated the need for a training program and attached a copy of a projected training program prepared by the Office of the Chief Clinical Psychologist.

The projected course required 26 days, of which 22 were to be teaching days. Clearance and concurrence were secured from the Surgeon General's Office for the content of the course and the hospital training to be conducted at Brooke General Hospital, Fort Sam Houston, Tex.[24] Since the Adjutant General's School was located on the same post as Brooke General Hospital and the psychologists who were newly commissioned were being detailed to the Adjutant General's Department, it was desirable to have this training activity under the Adjutant General's School. Four

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[23] Personal letter, Colonel Seidenfeld, to Col. George R. Evans, Chief, Classification and Replacement Branch, and Col. William C. Menninger, Director, Neuropsychiatry Division, SGO, 22 May 1944, subject: Training of Clinical Psychologists.

[24] It will be noted that the original idea of having the training conducted at five hospital centers was dropped. In a conversation on 11 August 1945, Dr. Walter V. Bingham gave, purely as an opinion, two reasons for this move. Hospital psychiatrists were tremendously overworked. The help they would receive from the student psychologist would be less than the work entailed. Furthermore, a review of the qualifications of the students of the first two or three classes indicated more clinical experience in hospitals than had been expected; it was, therefore, not essential that all the training take place in a hospital center.—M. A. S.

instructors were initially supplied to the school from the Office of the Chief Clinical Psychologist.[25]

Psychologist School

Permission for the establishment of the course was granted by the Director of Military Training, ASF, in a first indorsement to the letter of 25 August 1944 (p. 578). This indorsement was dated 9 September 1944 and authorized the establishment of—

> * * * a course for Clinical Psychologists at The Adjutant General's School, Fort Sam Houston, Texas, with a capacity of 24 officers. The estimated total to be trained is 144 officers, and will require 6 classes of 22 training days' duration with the first class starting on or about 1 October 1944. No increase in the total capacity of The Adjutant General's School is authorized.

Approval of the submitted program of instruction was also included. The scope of this program included a review of testing and interview techniques, hospital procedures, types of problems encountered, diagnosis, clinical techniques, and therapeutic measures in dealing with neuropsychiatric patients in Army hospitals.

Objectives

The proposed duties of the clinical psychologist were considered to represent the goals to be achieved by the training program. These duties, as set forth in WD Circular No. 270 and amplified by War Department Technical Bulletin (TB MED) 115, "Clinical Psychological Services in Army Hospitals," dated 14 November 1944, were as follows:

a. Aid in the development and administration of the program of counseling designed to prepare convalescent patients for return to military service.

b. Assist in the preparation of clinical records, particularly including those requiring the use and interpretation of special psychological tests as desired by the chief of the neuropsychiatric section.

c. Assist in studies of special psychological problems related to the classification and retraining of neuropsychiatric casualties.

d. Assist in the determination of the appropriate military occupational specialty of men who are designated as ready for assignment, and to advise regarding their assignment to a specific duty or special training.

e. Perform such other professional and administrative duties in the hospital as will best assist the neuropsychiatrist in the accomplishment of the best management and disposition of patients.

Sievers,[26] in discussing the training of students at the Adjutant General's School stated:

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[25] The four instructors in clinical psychology, assigned to the Adjutant General's School, who prepared the first set of detailed lesson plans for the program of instruction were Captain Sievers and Lts. Paul C. Greene, Max L. Hutt, and Henry Sisk.

[26] Sievers, C. H.: The Current Program of Instruction for Clinical Psychologists at the Adjutant General's School. J. Clin. Psychol. 1: 130–133, 1945.

In many instances, formal psychometric testing is a minor responsibility of the psychologist, most of whose time is spent in taking case histories, conducting psychological interviews and group psychotherapy, or in various phases of the educational or physical reconditioning program. Other units, however, often require routine testing of all patients thus making formal psychometrics the major part of the psychologist's task. It was therefore decided that the course should contain a broad fund of information. * * * The second major problem to be considered involved the variation in the professional backgrounds of the student officers to be trained.

This led to the decision to include strong clinical orientation wherever possible in the training course.

Curriculum

The subject contents of the Clinical Psychology Course and the hours of instruction were as follows: [27]

Subject	*Hours of instruction*
The Organization of the Neuropsychiatric Section of a Hospital	4
Hospital Record Keeping	2
Psychological Examination	2
Psychological Instruments	7
Test Interpretation	5
History Taking	5
Interview Techniques	3
Mind-Body Relationships	2
Psychodynamics of Behavior	4
Major Types of Mentally Disturbed Patients	22
Brain-Injured Patients	4
Seeing the Whole Patient	3
Examinations	6
Miscellaneous military subjects	19
Total	88

In addition, 96 hours of applicatory training were given in the neuropsychiatric section and reconditioning center of an Army hospital.

Problems encountered

Insufficient time.—It became apparent that the course of instruction was entirely too cramped for time. A total of 22 working days did not provide sufficient time for even the minimum of military knowledge to be attained and crowded the training in the professional subjects far too much.[28] As a result, with Class 5 (3 March 1945), a new program which

[27] See footnote 26, p. 579.

[28] At the first meeting of the Advisory Board on Clinical Psychology, 6–7 November 1944, the members discussed this problem and recommended lengthening the course. At its second meeting, on 29 March 1945, the board again called attention to the fact that the time allowed was insufficient to "familiarize student officers with the complicated duties they are called on to perform in close collaboration with psychiatrists and psychiatric social workers."—M. A. S.

required 34 days of actual training time was introduced. The authorized size of the class was increased to 50 officers to compensate for the time increase.

Limited facilities.—When the Adjutant General's School moved to Camp Lee, Va., the facilities at Camp Lee were too limited for the proper training of clinical psychologists. In an informal discussion, Lt. Col. Wayne A. Starkey, MC, of the Training Branch, and Colonel Menninger of the Neuropsychiatry Consultants Division, both of the Surgeon General's Office, Lt. Col. (later Col.) Douglas A. Thom, MC, Neuropsychiatric Consultant of the Second Service Command, and Colonel Seidenfeld agreed that Mason General Hospital, Brentwood, Long Island, N.Y., with the added facilities of the convalescent hospital at Camp Upton, N.Y., was the most desirable location for the training of clinical psychologists. This decision was considered appropriate since the training of neuropsychiatrists was also given at Mason General Hospital. As a result, it was recommended that the course for clinical psychologists in its entirety be transferred to Mason General Hospital but that it remain under the Adjutant General's School for administrative purposes. However, with the proclamation of V–J Day and the subsequent cancellation of the unexpended portions of the procurement objectives for clinical psychologists, no final action was taken on the recommendation. Class 8 was the last class in clinical psychology at the Adjutant General's School.

Results

By the end of September 1945, there had been eight classes in the Adjutant General's School "Officer's Course—Clinical Psychology." A total of 281 students were graduated. Only 3 percent of the men entering this school failed to do satisfactory work. The high degree of success in the school was additional evidence of the effectiveness with which the selection process had worked out in this program. More than 63 percent of all second lieutenants (new appointees) were rated superior or excellent by the school.

Informal Training

While the academic preparation of clinical psychologists was stressed in the selective process and further training was obtained through the clinical psychologist course at the Adjutant General's School, additional training was necessary so that standards could be maintained.

This was accomplished, first, by frequent visits to the field by the Chief Clinical Psychologist and his assistants and, second, by attendance at a number of conferences where many psychologists were assembled.

The visits included a variety of installations, such as all types of

hospitals, service command headquarters, disciplinary barracks, and rehabilitation centers. The conferences assisted officers in the field and provided a means for interchange of ideas, thus avoiding the emphasizing of "arm chair" procedures. Most valuable were a series of conferences held at service command level. These were encouraged by the Office of the Chief Clinical Psychologist, but the individual service commands selected their own time and date to meet the local situation. Conferences were held at the First, Fourth, Fifth, and Sixth Service Commands.

Postwar Changes

Upon completion of Class 8, the course for clinical psychologists in the Adjutant General's School was terminated because of the cancellation of procurement objectives. By this time, the entire clinical psychology program had been transferred to the Surgeon General's Office, and further training policy was provided within the framework of the Medical Department. Early in September 1945, the Training Division, SGO, was furnished a complete outline of the clinical psychologist training course together with recommended changes of content. After a conference with the Chief of the Neuropsychiatry Consultants Division, General Menninger, and the Director of the School of Military Neuropsychiatry, Col. William C. Porter, MC, it was agreed that further training of clinical psychologists would be under the jurisdiction of the School of Military Neuropsychiatry. Since the curriculum of this school was then undergoing reorganization, no definite length of course was decided upon. In February 1946, the School of Military Neuropsychiatry was moved to Brooke General Hospital, and its postwar plans were indefinite.[29]

Recommendations

Problems relative to professional training, interpretation of field policy, site of training, and other factors did arise. As a result, the following recommendations regarding training were made:

First, it is recommended that a direct liaison be established with the Adjutant General's School and the Office of the Chief Clinical Psychologist so that errors in the interpretation of field policy may be minimized.

Second, that selection of professional psychologists to carry on the psychological training (in contrast to other military subjects) will be made by the Office of the Chief Clinical Psychologist. Alterations in the professional personnel would likewise be made by the Chief Clinical Psychologist after consideration of the reasons for such changes

[29] Training programs for officers and enlisted men in clinical psychology were established at the School of Military Neuropsychiatry, Fort Sam Houston, in 1947–48. Such courses operated as needed during and since the Korean War, although in recent years the Department of Neuropsychiatry, Medical Field Service School, Fort Sam Houston, the successor to the School of Military Neuropsychiatry, only provides training in clinical psychology for enlisted personnel. Officer courses are on a standby basis to be used in the event of mobilization. Present standards for commissioning of officer clinical psychologists include a doctorate degree—A. J. G.

with the school. Concurrence with the Commandant, the Adjutant General's School, would be necessary before final placement is made.

Third, the content of professional courses would be controlled as to policy and practices contained therein by concurrence from the Chief Clinical Psychologist.

Fourth, the site at which training is given would be governed by the Chief Clinical Psychologist, The Surgeon General, and The Adjutant General.

Fifth, the major portion (at least 75 percent) of training would be conducted in a medical installation.

RELATIONSHIPS WITH THE ADJUSTANT GENERAL AND THE SURGEON GENERAL

Dual Supervision

War Department Circular No. 270 placed the clinical psychologist under the professional jurisdiction of the hospital psychiatrist, a medical officer.[30] However, the clinical psychologist, wearing The Adjutant General's shield, was under administrative control of the Adjutant General's Office, more specifically, of the Chief Clinical Psychologist. This dual supervision had in it the seeds of tension, referred to in a veiled manner in at least two documents, and much more explicitly in many conversations.

The Advisory Board on Clinical Psychology, in November 1944, recognized the "administrative difficulties involved in bringing about collaboration of psychological and medical personnel in the work of classification and disposition of neuropsychiatric casualties and records" but was gratified at the progress made in the resolution of the difficulty.[31] At the second meeting of the board, Capt. Beverley C. Holaday of the Second Service Command drew attention to "opposing pressures from higher authorities."[32]

The Surgeon General's Office by the very nature of the personnel and functions under its jurisdiction was fitted for professional control. In contrast, the Adjutant General's Office, because of its work and wider variety of assigned personnel, was better constituted for administrative control.

Like all the psychological programs of the Army, clinical psychology grew out of the need to insure proper assignment to duty, military education, and adaptation to the military society. It is not surprising, therefore, that the Personnel Research Section, Classification and Replacement Branch, AGO, should have provided the principal source of clinical psychologists.[33]

Some psychologists, working under the ægis of the Adjutant General's Office, were carrying out clinical functions before any formal designation

[30] The utilization of clinical psychologists in the Army Air Forces followed in general a similar plan to that encompassed in WD Circular No. 270 but did not place the psychologist jurisdictionally under the psychiatrist in the convalescent hospital.—M. A. S.

[31] Minutes, First Meeting, Advisory Board on Clinical Psychology, 6–7 Nov. 1944.

[32] Minutes, Second Meeting, Advisory Board on Clinical Psychology, 29 Mar. 1945.

[33] The Staff and Personnel Research Section, Classification and Replacement Branch, AGO: Some Aspects of the Relationship Between Personnel Research and Clinical Psychology in the Army. J. Clin. Psychol. 1: 105–112, 1945.

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of "clinical psychologist" had been established as an integral activity in the service. "Classification and Assignment Officers Personnel Consultants and others have made beginnings in this work in Consultation Services, Mental Hygiene Units, Development Training Units (later called Special Training Units), Rehabilitation Centers, and Separation Centers." [34]

However, the need for clinical psychologists in the neuropsychiatric program within Army hospitals became so great that The Adjutant General was asked to furnish properly trained clinicians for this purpose. Thus, the Office of the Chief Clinical Psychologist was established initially in the Classification and Replacement Branch, AGO, paralleling the already existing Personnel Research Section.

Unfortunately, such a complicated hierarchy made adequate professional guidance and contact difficult for the Chief Clinical Psychologist.[35] Lack of direct contact with the Office of the Chief Clinical Psychologist was definitely felt in the field. Capt. Lawrence I. O'Kelly, MAC, reported: "A closer contact between the Service Command and the Office of Chief Clinical Psychologist on professional psychological questions was a desire expressed by most clinical psychologists in the First Service Command." [36]

Transfer of Clinical Psychologists to the Medical Department

While close liaison was maintained between the Neuropsychiatry Consultants Division and the Office of the Chief Clinical Psychologist, it was evident that inclusion of clinical psychologists in the Adjutant General's Department had several disadvantages. Thus, in the field, service command supervision of clinical psychologists was largely delegated to personnel consultants. In many instances, personnel consultants were not clinical psychologists and possessed little knowledge of hospital procedures or requirements. Inspection from these officers of the Adjutant General's Department was not uniformly welcomed by hospital commanders. There was no administrative channel through which service command supervision of clinical psychologists could be delegated to responsible Medical Department authorities. This created difficulty in assignment and supervision of professional work.

After a series of conversations between the Neuropsychiatry Consultants Division, SGO, and the Classification and Replacement Branch, AGO, Maj. Ivan C. Berlien, MC, of the Neuropsychiatry Consultants Division and Captain O'Kelly of the Classification and Replacement Branch were ordered to prepare a staff study recommending the transfer of the entire clinical psychologist program to the Office of The Surgeon General. This study,

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[34] See footnote 33, p. 583.

[35] Conversation with Capt. Lawrence I. O'Kelly, Assistant Chief Clinical Psychologist, 7 Aug. 1945.

[36] Memorandum, Office, Chief Clinical Psychologist, for Chief, Neuropsychiatry Consultants Division, SGO, 26 June 1945, subject: Semi-monthly Report.

completed and forwarded to the Assistant Chief of Staff, G–1, on 4 August 1945,[37] presented the following:

I. *THE PROBLEM:*

The desirability of detailing to duty with the Medical Department of these Clinical Psychologists presently or in the future working in medical installations who are commissioned in The Adjutant General's Department.

II. *DISCUSSION:*

1. Clinical Psychologists are at present commissioned in The Adjutant General's Department, but the majority are assigned to Medical Department installations where they perform clinical professional duties in conjunction with medical officers in the testing and treatment of patients.

2. Personnel involved: A total of approximately 339 officers and 2 civilian aids are involved.

3. Advantages of transfer: Because the duties of Clinical Psychologists are essentially of a medical nature their supervision and teaching should properly be administered by the Medical Department, whereas, at present, these functions can only be done by The Adjutant General.

4. Nothing herein is intended to reflect upon the outstanding service of The Adjutant General to Medical Department. The Adjutant General concurs in this study and its recommendations.

III. *RECOMMENDATIONS:*

1. That the Adjutant General's Department Clinical Psychologists be detailed to duty with the Medical Department.

2. That the Chief Clinical Psychologist, his Assistants, and civilian aids be moved to the Office of The Surgeon General as a Branch of the NP Consultants Division and the allotment of authorized personnel be increased accordingly for officers and civilians.

IV. This recommendation has been concurred in by Army Air Forces (Lt. Col. Dale Rice) and by The Adjutant General (Col. Frederick S. Foltz, Chief, Classification and Replacement Branch).

The recommendations of the staff study were supported by a statement of the duties and functions of the clinical psychologists, abstracted largely from TB MED 115, and also by a statement of the major reasons for requesting the transfer, as follows:

1. Supervision at Service Command level of clinical psychologists is at present largely delegated to the Personnel Consultant of the Service Command, who may not be a clinical psychologist himself, and is not trained in army or civilian hospital procedures or requirements. Although he works in cooperation with the Service Command Neuropsychiatric Consultant, there is no clear-cut division of supervisory responsibility.

2. War Department responsibility for assignment of clinical psychologists is in The Adjutant General's Department, although assignment of clinical psychologists should be handled by the agency with the most intimate knowledge of the changing needs of neuropsychiatric sections of medical installations, i.e., Surgeon General's Office. Economy and efficiency of utilization would be promoted by closer coordination in assignment.

3. The professional work of the clinical psychologist is done for and in the Medical Department, and is under the control of the Surgeon General's Office. It would be desirable to place the administrative responsibility under the same department for more effective coordination with the professional duties.

[37] Memorandum, Col. Robert J. Carpenter, MC, Executive Officer, for War Department, Assistant Chief of Staff, G-1, thru: The Commanding General, Army Service Forces (attention: The Director, Military Personnel), 4 Aug. 1945, subject: Clinical Psychologists.

4. Supervision and professional assistance at the War Department level by the Chief Clinical Psychologist as a representative of The Surgeon General.

5. The task of developing testing and therapeutic procedures for use in neuropsychiatric services can best be accomplished within the Surgeon General's Office, where psychiatrist and psychologist can work in more effective cooperation.

6. Training of clinical psychologist has largely taken place outside medical installations, although one of the primary aims of training is to perfect techniques of working with patients. Training should properly be done in hospitals where clinical material and psychiatric instruction is readily available.

Following the initiation of this proposal, there was a meeting of Colonel Menninger and Colonel Foltz of the Classification and Replacement Branch in which it was agreed that the procurement objective of clinical psychologists would remain with The Adjutant General and that any psychologists who became surplus to the needs of The Surgeon General would be made available to The Adjutant General for assignment. The entire request was approved by Assistant Chief of Staff, G–1, on 17 August 1945, and WD Circular No. 264, effecting the transfer, was issued on 1 September 1945.

All clinical psychologists were then detailed from the Adjutant General's Department to the Medical Department as MAC (Medical Administrative Corps) officers. The Office of the Chief Clinical Psychologist was transferred to the Surgeon General's Office and became the Clinical Psychology Branch of the Neuropsychiatry Consultants Division. Service command supervision of clinical psychologists became the responsibility of the service command neuropsychiatric consultants. During the short time of its operation, the Clinical Psychology Branch proved to be extremely effective.

Reactions of clinical psychologists.—There was some reaction from psychologists in the field both for and against the transfer to the Surgeon General's Office. While they agreed that assignment to the Medical Department was desirable, many believed that their professional status would be threatened by incorporation into the Medical Administrative Corps. In general, they would have preferred the Sanitary Corps. Although the Sanitary Corps might have been more desirable, the matter is only of theoretical importance since a Sanitary Corps no longer existed within the Army structure. Some officers believed that a separate corps within the Medical Department should have been created. Later, with the reorganization of the Army Medical Department and the creation of a Medical Service Corps, this problem appeared to be solved.[38]

One cannot help being impressed by the wide variety of opinions that prevail about the professional psychologist and his proper "utilization" in the Army. Much of the hue and cry for a separate "Corps" for the psychologists appears to be derived from experiences gained from assignments

[38] Unhappily, the problem is not solved. It continues to erupt periodically as clinical psychologists as well as bacteriologists, biochemists, social workers, and others of the minority allied science section of the Medical Service Corps argue for a separate corps and for freedom from performing administrative and staff functions.—A. J. G.

in the Sanitary Corps, the Medical Administrative Corps, or the Medical Service Corps where they had been called upon, from time to time, to perform nonpsychological duties. The complaint has been that while they were carrying out these nonprofessional obligations patients have been deprived of their services.

One can hardly argue against the propriety of a professional person's desire to devote his time to bettering the lot of the patient. Yet, it is unwise and unrealistic to assume that under conditions of stress any officer can hope to limit himself solely to duties requiring only his specific skills. Actually, he shares dual professional responsibility—one, as a military officer; the other, as a psychological specialist. Assignment to a specific "Corps of Psychologists" would be unlikely to provide relief from administrative obligations carried out by all military officers regardless of the arm or service to which they are assigned.

There is also a professional obligation to "pinch-hit" for missing services which are essential in the best interest of the patient. Thus, there were times when the psychologist took on the role of a social worker or an educational officer because these services were needed and an appropriate specialist was not available. This, in general, the psychologist accepts and carries out without feeling badly "put upon." Similarly, such duty as Officer of the Day or as a member of a court-martial does, from time to time, fall "into the psychologist's lap" and must be accepted as part of the military profession, even though removed from the psychological sphere. Psychologists who accepted these duties gained a great deal by becoming more familiar with the military environment.

FUNCTIONS AND DUTIES

Medical Installations

Perhaps the best means of surveying the work performed by the clinical psychologists in medical facilities is to review the report of the War Department Personnel Audit Team which audited 33 medical installations, including 18 general hospitals, 7 ASF convalescent hospitals, 3 ASF regional hospitals, and 4 AAF convalescent hospitals.[39] In these hospitals, there were 79 officers, 236 enlisted personnel, and 4 civilians on duty in the clinical psychology program. This study was conducted "to ascertain if the needs of these installations were being adequately met and to determine if suggestions could be made to make the program more effective."

With the exception of two cases, all officer psychologists were found to be fully qualified. The two exceptions were officers who lacked technical background and had not been commissioned as clinical psychologists. With no exceptions, commanding officers, neuropsychiatrists, and chiefs of neuro-

[39] The material in this section is from the War Department Personnel Audit Team's report of 5 May 1945.

psychiatric sections were satisfied with the clinical psychology program. The neuropsychiatrists, especially, expressed the opinion that the assistance of the psychologists made it possible to increase the effectiveness of the psychiatric program and permitted them to devote more time to psychiatric functions. In all cases, satisfaction was expressed with the caliber of men commissioned to perform the duties of clinical psychologists.

Duties of clinical psychologists at the various hospitals were found to be varied. In most of the ASF installations, the clinical psychologists were performing duties directly related to the clinical field, which included testing, accomplishing case histories, and conducting individual and group psychotherapy. The emphasis on these functions varied from hospital to hospital but, for the most part, was confined to patients in the neuropsychiatric section. At some installations, it was found that the psychologists were involved more in administrative work than in actual clinical functions. In ASF convalescent hospitals, the chief psychologists were supervising the clinical program and acting as liaison officers with the reconditioning sections and the various educational therapy activities. At two convalescent hospitals, clinical psychologists were used to perform duties under the supervision of the director of convalescent training. This work involved supervision of the educational program and the classification and counseling activities, which duties would normally be performed by a separation, classification, and counseling officer as prescribed by ASF Circular No. 90, 12 March 1945.

In AAF convalescent hospitals, psychological personnel performed the following duties:

1. Initial and continuous orientation of patients to assist in self understanding and adjustment.
2. Initial evaluation of patients' abilities and interests for program placement, including followup and terminal contacts.
3. Counseling of all patients referred for any reason by personal physicians and psychiatrists.
4. Supervision of administrative duties and research in technical procedures for evaluation and improvements of the program.

In contrast to ASF convalescent hospitals, the psychological section of AAF convalescent hospitals provided psychological services for all patients in the hospitals, not being restricted to neuropsychiatric patients. Duties of the psychological staff in AAF convalescent hospitals were uniform, due to the organization prescribed by the Army Air Forces and Personnel Distribution Command.

In general hospitals, with the exception of those specializing in neurology and neurosurgery, clinical psychologists worked directly under the neuropsychiatrists. As has been stated, a definite lack of uniformity of organization was found in the ASF convalescent hospitals. In AAF convalescent hospitals, the psychological branch was a separate section under

the chief of professional services. This branch was headed by a chief psychologist who had four subordinate sections under his control.

In the 28 ASF installations studied, the total patient census was 73,031, of which 11,762 were neuropsychiatric patients. The 46 officer psychologists and 185 enlisted personnel assigned to these installations indicated a ratio of 1 officer psychologist to each 255 neuropsychiatric patients. Although the psychological section of AAF convalescent hospitals processed all patients, not just neuropsychiatric patients, it is significant that the ratio of officer psychologists to total patients was 1 to 207. If ASF convalescent hospitals were to have rendered similar services to all hospital patients, the ratio of officer psychologists to total patients would have been 1 to 1,025.

In the various installations visited, factors were encountered which hampered maximum utilization of the psychological services, as follows:

1. Lack of coordination of the clinical psychology program with other consultant services.—Activities of the personal affairs branch, the separation, classification and counseling section, and education reconditioning, particularly in general hospitals, were operating independently and not transmitting information from one to the other.

2. Psychological program confined largely to neuropsychiatric patients.—In 75 percent of the ASF installations visited, the psychological section rendered no professional services to patients in other sections of the hospital. In three general hospitals, there were no clinical psychologists desired because the installation understood the program to be restricted to neuropsychiatric sections. It is the judgment of the auditors that, while the hospital carried no patients classified as neuropsychiatric, clinical psychologists would do much to prevent such cases from developing.

3. Need for transmittal of pertinent information by Chief Clinical Psychologist.—In ASF installations, the majority of officer psychologists did not have knowledge of certain pertinent directives. Since directives are issued by various branches of the War Department, there is a need for coordination of this material which might well be furnished by the Office of the Chief Clinical Psychologist of AGO. Due to the recent inauguration of the clinical psychology program, individual officers felt the need for an exchange of techniques and ideas between installations, which could also be handled in the same manner.

4. Delay in filling requisitions for testing materials.

5. Need for standardized forms to record and transmit psychometric data.

6. Need for allotment for clinical psychologist personnel.—While it is recognized that service commands are required to perform their missions with the personnel allotments authorized, the clinical psychology program has been initiated with no provision in local installations for increased allotment. This has resulted in some installations being reluctant to obtain sufficient number of personnel to carry out the program.

7. Psychotherapy in ASF convalescent hospitals minimized by emphasis on separation.—It was found that arbitrary rates of discharge from these installations have been prescribed by higher headquarters. While it is realized that there is a need for a rapid turnover of patients in convalescent hospitals, psychiatrists and psychologists stated that patients were not receiving the amount of treatment they felt desirable.

The Personnel Audit Team recommended that consideration be given to revising Section IV, WD Circular No. 71, 1945, to expand the scope of the clinical psychology program to include all patients in medical installations. It further recommended that a standing operating procedure

be prepared to include such points as an outline of the duties of the clinical psychologist, a clarification of his position in the functional organization, methods to bring about a better coordination of the clinical psychology program with other consultation services, and a standardization of procedure for recording and transmitting psychometric data.[40]

Role of Psychologist on Psychiatric Team

Psychologists had worked with psychiatrists as well as with other medical practitioners long before World War II. Unfortunately, the number of such working relationships had been rather limited. The number of "clinical psychologists" were so limited that the Clinical Division of the American Psychological Association had difficulty in keeping itself alive. The relatively few members often felt dissatisfied and frustrated in attempting to attain recognition because they were so completely overwhelmed by the academic as well as the applied branches of psychology. This lack of importance of clinical psychology was further emphasized by the relatively small role assigned this field of endeavor in the development of the psychological program of the Army within the Personnel Research Section, AGO. It was not until Colonel Menninger and a few of his associates began to make an appeal for clinical psychologists to meet the demands for overall psychological services that attention was paid to utilizing this professional group.

Once the need was recognized and competent clinical psychologists procured, they were well received by the psychiatrists. Especially valuable were those clinicians, with excellent prewar training and experience, who had developed keen clinical judgment, professional integrity, and ability to work in an orthopsychiatric environment without feeling threatened by medical and allied medical personnel.

Only in rare instances were serious conflicts or antagonisms expressed by the psychiatrist for the psychologist, or vice versa. These occurred in those instances where either, or both, the psychiatrist or the psychologist concerned had been inadequately prepared for working in a joint relationship. Then, the more threatened individual often projected his fears and anguish upon his coworker. This points up the necessity for continuing a close working relationship between the psychiatrist, the psychiatric social worker, and the clinical psychologist in the peacetime Army. When professional personnel work together over a long period of time, they develop mutual respect and understanding of what each can do for the other and for the patient. Out of such a relationship, a better functioning team approach will exist in the future.[41]

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[40] Before any action was taken on any of these recommendations, the whole clinical psychology program was transferred from the jurisdiction of The Adjutant General to that of The Surgeon General, as authorized by WD Circular No. 264, 1 September 1945.—M. A. S.

[41] Menninger, *op. cit.*, p. 245.

The following extract from the report given by Rein and his associates,[42] at the Neuropsychiatric Conference of the Sixth Service Command held in Chicago, Ill., on 16–17 November 1945, is illuminating and serves as a typical example of the relationship that existed between psychiatrist and psychologist:

> The clinical psychologists were made part of a psychiatric team with specific duties * * * the combined efforts of psychiatrists, psychiatric social workers, clinical psychologists, occupational therapists, instructors in arts and skills and reconditioning officers and instructors are needed to make the program succeed.

In describing the organizational plan of the neuropsychiatric section of a convalescent hospital, Rein and his associates stated, as follows:

> * * * that it is that of a regiment with four battalions. Each battalion is further broken down into four companies, each with a capacity of 100 patients. Hence, at maximum capacity, there would be 1,600 patients in the neuropsychiatric section. There are 11 commissioned psychologists and 10 enlisted psychologists allotted to assist the psychiatrist in the diagnosis and treatment of a possible 1,600 patients.
>
> * * * The duties of the Regimental Psychologist are primarily to supervise and coordinate the psychological program for the four battalions. He holds weekly meetings in which each psychological unit of each battalion may express itself as to improving the psychological services. Results of techniques and methods used by the different psychological units are discussed and modifications may be made to attain the best ones so that the psychologist will make a maximum contribution to the psychiatric team. He puts into effect policies and plans bearing on psychological work that the Chief of Neuropsychiatric Service may request.

In their report, the authors pointed out that the regimental psychologist is responsible for "coordinating the program of the regiment." As a result, the regimental psychologist could aid the chief psychiatrist "in seeing that at all times, the several aspects of the daily program are observed for their effect upon the neuropsychiatric patient." He was also in a position to maintain "a close liaison * * * with the occupational therapy and educational and physical reconditioning sections of the Convalescent Hospital."

They also indicated that it is at the battalion level "that the real psychological work is done." Usually, two commissioned and two enlisted psychologists were responsible for carrying out the following three main functions: "One, psychometrics; two, individual and group therapy; three, vocational counseling and placement. All three functions are closely coordinated with the psychiatrist and the psychiatric social worker."

It is fortunate that, in the postwar setting of the Percy Jones Convalescent Hospital as described in this report, "all new patients, in the course of their processing, are seen by the psychologist," who was able to utilize the "quick screening devices" in getting at patient adjustment problems promptly. They were thus able to reassure and prepare the patient

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[42] Rein, B. D., Brown, W., and Allyn, M.: The Position of the Psychologist on the Psychiatric Team. *In* Proceedings of the Neuropsychiatric Conference, Sixth Service Command, Chicago, Ill., 16–17 November 1945, pp. 185–187.

for his prehospitalization furlough as well as deal with his psychiatric needs more effectively upon his return to the treatment center.

Capt. Ray S. Miller,[43] in discussing this report at the same meeting, emphasized: "The psychiatrist has been sold first of all on the skill and efficiency of the clinical psychologists who have been assigned to work with him. The effectiveness of the team work outlined in this paper probably depends more upon the individuals of the team than upon the tools with which they work."

In hospitals and clinics.—Few people were aware of the extent and breadth of services rendered by the clinical psychologist in hospitals, clinics, and a variety of treatment situations both in the Zone of Interior and in all oversea theaters. TB MED 115 outlined some of these duties but at least a few deserve special attention, from a historical point of view.

So far as the type of treatment facilities in which the clinical psychologist served, perhaps the most important were the named and numbered general hospitals. Here, he was generally a part of a large neuropsychiatric service in which team relationship was most likely to be stressed. As a rule, the psychologist learned to work cooperatively with the psychiatrist and the psychiatric social worker in developing the complete picture of the patient's problems and their correction. Here, he was exposed to clinical conferences, rounds, and even "post-mortems" that permitted him to see just how his role was clinically important and to recognize the areas for further professional growth.

Because the patient was often in the general hospital for a lengthy stay, the clinical psychologist had the opportunity to participate in a therapeutic role. Where he possessed the necessary training and skill and his psychiatric associates properly appraised his capabilities, he often was given wide latitude in exercising this professional function, thus doing his best work. These experiences were rich and rewarding to the patient as well as to the psychologist.

Not all psychologists working in the general hospitals were equally well equipped to accept or carry on these professional roles, especially the therapeutic ones. However, some who were undoubtedly well trained may have encountered psychiatrists who because of past experiences, bias, or basic insecurity were unwilling to use the psychologist except for the most prosaic or unimaginative types of duty. By and large, however, this was the exception rather than the rule. The psychiatrists generally were quick to discover information indicative of the preparation of the psychologist to participate in both diagnosis and treatment and, after a short period of observation, sought to place the psychologist in a position of responsibility commensurate with what the psychiatrist was convinced he could do. As a rule, this was fairly accurate placement and served to please both professional workers and reflected in the clinical improvement of the patients.

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[43] Miller, R. S.: Discussion of the Position of the Psychologist on the Psychiatric Team. *In* Proceedings of the Neuropsychiatric Conference, Sixth Service Command, Chicago, Ill., 16–17 November 1945, pp. 188–189.

In a somewhat similar fashion, psychologists assigned to convalescent centers were utilized fairly promptly in accordance with their real and potential abilities.

In the mental hygiene units and consultation services, psychologists often achieved the most professional gratification. Working with psychiatrists and social workers who were enthusiastic in the development of a program that had a heavy weighting in "preventive psychiatry," it was obviously a rewarding kind of work. Psychologists who worked in this type of environment, like their professional colleagues from the medical and paramedical professions, derived the satisfactions that came from minimizing the traumatic effects of the environment and in seeing many of their patients return to duty with the least possible delay. There is something extraordinary in knowing that one has prevented illness. Clinical psychologists fortunate enough to participate in such programs often became imbued with an appreciation for the mental hygiene approach which they carried back to civilian life.

Summary.—Clinical psychologists performed a wide variety of services in the various treatment environments. They worked in the areas of diagnosis and treatment and served as consultants on classification and assignment of the recovered patient. In some medical facilities, they worked not only with the psychiatrist but also with other medical specialists, including the neurologist and audiologist, and dealt with problems of such handicapped patients as the paraplegic and monoplegic, the blind and visually defective, the deaf and hard-of-hearing, and the aphasic and language disorders. Their utilization was as broad as their training and adaptability and the latitude permitted by their senior officers.[44]

Correctional Facilities

A few psychologists actively participated in programs centered around the treatment of the recidivist in the disciplinary barracks. They worked closely with the psychiatrist and the social worker in attempting to get at the sources of the deviant behavior.

By directive, general prisoners "who are judged to be restorable and who have more than six months of their sentence to serve are to be sent to a Rehabilitation Center." Goldberg,[45] in his description of the training program in the rehabilitation centers in the Army, reported:

> A considerable percentage (about 50%) of the men forwarded to a Rehabilitation Center do succeed in having their dishonorable discharges suspended and their sentences eventually fully remitted. Some men in Disciplinary Barracks are similarly honorably restored to duty, although the percentage is much smaller than that of the Rehabilitation Center.

General prisoners were assigned to such rehabilitation programs in

[44] See footnote 15, p. 574.

[45] Goldberg, S.: The Rehabilitation of General Prisoners in the Army. J. Clin. Psychol. 1: 126–129, 1945.

terms of their "demonstrated ability to get along in the training program of the Rehabilitation Center" as well as upon an evaluation of their basic personality structure.

The psychologist's role was primarily in the determination of intellectual capacity and assessment of personality. Then, in collaboration with the psychiatrist and social worker, the psychologist frequently assumed a treatment role especially in group therapy, although from time to time he was called upon to administer individual therapy under competent psychiatric supervision.

This program was administered under the Division of Psychiatry and Sociology (p. 493) which "functions very much like a Classification Board in civilian penal institutions." Members of this division determined the restorability of the prisoner, carried out treatment, and made appropriate recommendations to the commandant and the Clemency Board when the prisoner was considered eligible for restoration to duty.

Generally, prisoners were held at least 6 months in a rehabilitation center, of which time half was spent at the prehonor training level and half at the honor level. The training basis was largely determined by the literacy of the prisoner. During the prehonor period, 24 hours a week were spent in work and an equal period in training. The training included instruction in reading, arithmetic, language expression on the academic side, infantry drill, physical conditioning, and Army orientation to provide military preparation. In addition, group therapy was also provided.

At the honor level, additional Army orientation, individual and group therapy, some technical training, and extensive basic military training was provided on a 48-hour-per-week basis.

According to Goldberg: "The training program represents a sound educational, psychological and military approach to the problem of rehabilitation of prisoner personnel."

Induction Stations

While induction stations were primarily charged with the general task of determining, by examination, the mental, physical, and moral suitability of registrants for military service, one of their most difficult responsibilities was psychological assessment in terms of the mental standards established by each of the components of the Armed Forces.

Late in 1940, the War Department announced that it would not accept for induction men who had been discharged from the Regular Army or Navy because of "inaptness," nor would men "who cannot understand simple orders given in the English Language" be inducted "until such time as the War Department authorizes the establishment of special training battalions."

Numerous and varied were the procedures initially tried to screen out men who could not reach the rather loosely defined standard of literacy.

Ultimately, it was agreed that the standard to be met was "fourth grade literacy" and was to be given psychological recognition by the development of a "minimum literacy test," from the Personnel Research Section, the Adjutant General's Office.

While it was hoped that these tests would, for the most part, be administered at the level of the local selective service boards when the registrant came in for his physical examination, this was not actually put into practice. The determination of literacy was, for the most part, carried out by psychiatrists at the induction stations.

Public demand for the induction of many men who had been turned down because of deficits in their literacy culminated in a change in policy.[46] This authorized the induction of 10 percent of white and 10 percent of Negro registrants processed each day at each induction station, who could neither read nor write English at a fourth-grade level provided they could understand simple orders in English and possessed "sufficient intelligence to absorb military training rapidly."

To make the determination of inductees who were capable of meeting these standards, the Personnel Research Section developed the Visual Classification Test which was introduced at induction stations on 1 August 1942. This test relied upon pantomime to convey directions, and while it did not actually fully meet the stated criteria, it did at least help select men who might reasonably be expected to learn the duties of a soldier if given a minimum amount of training in the use of language.

While, initially, the psychiatrist had been administering the literacy tests, with the introduction of intelligence as a criterion for induction, it was deemed necessary to provide psychologically trained personnel to determine minimum mental capacity.

It was readily apparent that there were not a sufficient number of available trained psychologists in the Army to cover induction stations. There were, therefore, 140 psychologists commissioned as first and second lieutenants and assigned as personnel consultants to induction centers.

Psychological personnel assigned to induction stations were given specific technical training by the service command personnel consultant, or by other qualified personnel, before they assumed their duties.

The role which the psychologist played in the induction station did much to lessen the problem of special training units by providing an effective screening for the majority of men who could not meet the demands for learning even under the most optimal of circumstances which the rapidly expanding Army could provide.

MENTAL AND EDUCATIONAL DEFICIENCY

One of the most immediate clinical problems in which psychologists

[46] War Department Circular No. 169, 1 June 1942.

were invited to participate was that of the illiterate soldier and of the individual with less than normal capacity for learning.

Magnitude of the Problem

It has been estimated that some 692,100 registrants were classified as IV–F because of mental deficiency, as of August 1945, either because they could not meet the minimum educational requirements or because they were unable to pass the mental tests applied in World War II. Some 4.3 percent of the registrants examined during World War II were thus so classified. (See appendix A, tables 5 and 7.) Actually, this percentage was surprisingly low.[47] This low percentage may be explained by the fact that prescreening tests as such, as well as the standards based on these tests, varied greatly in World War II, depending on the military needs. Thus, Menninger [48] stated:

> Induction policy in regard to the educationally deficient varied as the manpower needs fluctuated. Initially, from May 15, 1941, to August 1, 1942, when a quality army was the goal, there were more rejections for, and less discrimination between, mental and educational deficiency. From August 1, 1942, until February 1943, 10 percent of the inductees could be illiterates. Only 5 percent were allowed between February and June 1943. Again the policy was changed, and from June 1943, until September 1945, all illiterates were inducted if they could pass certain tests. After September 1945, only those illiterates then in the process were to be inducted.

Variance in the numbers inducted was not due to any basic consistency in the utilization of this category of personnel but rather to an expedient approach to the demands of the public that the military find ways and means of utilizing the less adequate in at least the same proportion as they were being used in the civilian industrial scene.

Actually, on the basis of an analysis of the Army General Classification Test scores of some 10 million men, Bingham [49] pointed out that in Grade V (the lowest level of intelligence) there were 8.8 percent of such individuals in the services. This, in itself, was not too serious a problem, but during the period from January 1942 to December 1945, some 29,000 patients were admitted to hospitals for disorders of intelligence, constituting 2.6 percent of all patients admitted to hospitals for psychiatric conditions (see ch. IX, table 8). About 15 percent of these patients were admitted overseas.

It is rapidly apparent that during a major emergency many thousands of individuals are brought into the Military Establishment who are not readily capable of adapting themselves to its rigors. Some can, with

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[47] On the basis of the current standards, it has been estimated that about 10 percent of the examined youths could not meet the minimum requirements as established by the Armed Forces Qualification Test. *See* Karpinos, Bernard D.: Qualification of American Youths for Military Service. Medical Statistics Division, Office of The Surgeon General, Department of the Army, 1962, table 5, p. 26.—A. L. A.

[48] Menninger, *op. cit.*, p. 203.

[49] Bingham, W. V.: Inequalities in Adult Capacity—From Military Data. Science 104: 147–152, 16 Aug. 1946.

special training, be prepared to render useful services. Others cannot be utilized for any but the simplest assignments. In a static situation, this problem would not be insurmountable; however, unfortunately, the number of such limited personnel inducted reaches its peak during maximal mobilization when the military is undergoing its greatest stress. World War II has taught that this problem could and should be solved during peacetime.

Special Training Units

Out of this problem of illiterates and mentally defective personnel grew the need for establishing a military unit capable of coexisting at a regular military training establishment, with the goal of educating and orienting these men to at least a minimal functional command of basic educational skills. Thus, such marginal personnel could complete their military training and, subsequently, carry out their duties, perform useful work in their units, and protect their associates as well as themselves. This was accomplished without embarrassment to the soldier or to the service. A report of how this was done follows.

Plans and preparation.—In August 1942, Colonel Seidenfeld was directed to set up a program for the education of personnel found to be mentally or educationally retarded and for the relatively few with minimal physical limitations, such as poor coordination or inadequate motor control. These became the STU (special training units) of the Army. Earlier, Lt. Col. (later Lt. Gen.) Walter Weible and his associates worked on the adaptation of a number of texts and training devices used for a similar program developed by the Army when the Civilian Conservation Corps had been in operation. Examination of this material made apparent its unsuitability for the Army program. It was clear that more functionally suitable training materials had to be developed. Colonel Seidenfeld requested permission to commission from civilian life a number of experts competent to prepare such materials. Among those brought in were Capt. (later Maj.) Henry Beaumont, Maj. Paul Witty, Capt. Samuel Kirk, and Capt. (later Maj.) Samuel Goldberg.

At about the same time, a small cadre of enlisted men, all of whom were skilled artists and cartoonists, was assigned to handle the very necessary artwork.

With this team assembled, the task was that of preparing suitable texts for training men not only in the basic "3 R's" but also in an understanding and acceptance of military conduct, morale, and discipline. Out of this need, "Private Pete" was born—a figure who was to become the pattern for the educationally limited personnel. The excellent work of these officers and enlisted men made the task of educating thousands of men a month a reality.

PSYCHOLOGICAL TESTS

In the early days of the psychological program, no definite instructions concerning the selection or the use of psychological tests had been issued. Each psychologist used those tests which he personally owned or which could be procured through local funds. In general, the tests selected conformed with acceptable civilian practice and with the training of the examiner. Army-wide distribution of testing equipment was confined to those instruments supplied by The Adjutant General Supply Depots. These were primarily group tests and, for the most part, were of little direct help for use in a clinical setting.

Authorization of Testing Materials

Because of this situation, TB MED 115, the material for which was prepared by the Office of the Chief Clinical Psychologist, was issued (p. 579). This bulletin briefly outlined the duties of clinical psychologists and provided uniform standards with respect to procedures and tests. It established procurement channels for obtaining testing supplies and prescribed certain tests as officially recognized. In recognition of the fact that a completely rigid acceptance of some tests and exclusion of others was unwise, it stated: "Tests not included on the above list will not be supplied unless for special reasons. These reasons should be presented in support of the particular request." In practice, the tests listed in TB MED 115 were sufficient for most installations. The outstanding exception was in certain convalescent hospitals with many illiterate patients who could be more adequately tested with the Stanford-Binet Intelligence Test than with the prescribed Wechsler-Bellevue Intelligence Scale. Pertinent extracts of TB MED 115 are, as follows:

> 5. TESTS. The Army General Classification Test, Forms 1c and 1d, and/or its replacement which will be available in the near future, and the Wechsler-Bellevue Intelligence Scale should ordinarily suffice as instruments for the measurement of intelligence. There are additional psychological tests which are authorized and available for general use in the Army. A list of these tests and the places or situations for which they are primarily intended is presented below as a matter of information for the clinical psychologist. Unless otherwise specified, the listed tests (when their use is justified) and the Army General Classification Test may be obtained from adjutant general depots. Requests for the Wechsler-Bellevue Intelligence Scale should be forwarded to the Office of the Chief Clinical Psychologist, Classification and Replacement Branch, The Adjutant General's Office.
>
> For personality evaluation, the Rorschach Test, the Murray Thematic Apperception Test, and the Minnesota Multiphasic Test should be adequate. These are available on request through channels to the Office of The Surgeon General.

Test	*Situation or place of primary use*
Arithmetic Test EA–3, X–1	WAC.
Army General Mechanical Test MA–2 and MA–3	Reception Center.
Army Radio Code Aptitude Test ARC–1	Reception Center.
Classification Test R–1	Induction Station and WAC.
Clerical Aptitude Test CA–1	Training Center.
Clerical Aptitude Test CA–2, X–2	WAC.
Crytography Test TC–4a	Basic Training Ctr (AAF)
Dictation Test	Training Center and WAC.
Driver and Automotive Information Test TK–2, X–1	WAC.
General Electrical and Radio Information Test TK–1, X–2	WAC.
General Technical Test TC–2a	Basic Training Ctr (AAF).
Group Target Test—1 GT–1	Induction Station.
Individual Examination IE–1	Induction Station.
Interview Aids for Occupational Specialists	Reception Center.
Mechanical Aptitude Test MA–4, X–1	WAC.
Non-Language Test 2abc	Training Center.
Non-Language Individual Examination NIE–1	Induction Station.
Nut and Bolt Manual Dexterity Test TC–5a	Basic Training Ctr (AAF).
Oral Trade Questions	Reception Center & WAC.
Qualification Test—1 and 2	Induction Station.
Radiotelegraph Operator Aptitude Test ROA–1, X–1	Reception Center & WAC.
Technical Trade Test TC–7a	Basic Training Ctr (AAF).
Trade Information Test TC–1a	Basic Training Ctr (AAF).
Typing Test	Training Center & WAC.
U-Bolt Assembly Test TC–6a	Basic Training Ctr (AAF)
Weather Aptitude Test TC–3a	Basic Training Ctr (AAF)
Women's Classification Test WCT–2	WAC.

It is obvious that many of the tests listed above, and especially group tests, will have no direct application in the hospital situation. A general policy which may serve as a guide in regard to test requisitions is to limit requests to those tests which are actually needed and whose use in the hospital can be justified. Duplication of tests should be avoided. There is no point in asking for two or more tests which have the same primary use. Tests not included on the above list will not be supplied unless for special reasons. These reasons should be presented in support of the particular request.

For testing intelligence and differential intellectual impairment, the Army General Classification Test and the Wechsler-Bellevue Intelligence Scale were authorized. For personality evaluation, the Rorschach Test, the Murray Thematic Apperception Test, and the Minnesota Multiphasic Test were considered to be adequate. These tests were authorized for procurement through medical supply channels to the Surgeon General's Office. Later, the Bender-Gestalt Test was supplied. In April 1945, it became apparent that the neurology services of Army hospitals would be handling a large number of patients with head injuries. Accordingly, TB MED 155 was issued, which was concerned primarily with establishing diagnostic and language therapeutic procedures with aphasic patients. This bulletin authorized the procurement and use of the Goldstein-Scheerer Test of Abstract and Concrete Behavior.

Handbook.—As a means of furnishing the psychologist with further

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flexible aids to examination, a handbook of miscellaneous testing material was issued.[50] The material for this handbook was prepared by Dr. Frederic L. Wells of Harvard University and by Dr. Jurgen Ruesch of the Langley-Porter Clinic of San Francisco. These authors generously relinquished their copyrights for the purposes of Army publication. The final handbook was 128 pages in length and contained both verbal and pictorial material. It proved extremely useful in the field, particularly in those installations where other testing material was slow in arriving. Many psychologists have suggested that this handbook be expanded, for future use, into a complete examination kit, which would be issued individually to each psychology officer.

Difficulties Encountered

The greatest single difficulty with testing procedures in Army psychology arose in connection with the problem of supply. Although official recognition and authorization for procurement of materials was accomplished relatively early in the program, by the end of the war officers in the field were still waiting for testing equipment. Many orders were not filled for as long as 10 to 15 months after having been approved by the Surgeon General's Office. The most difficult item was the Rorschach Test. The test plates, 10 ink blots mounted on thick cardboard, were printed by a Swiss firm which held an exclusive copyright; only two firms in the United States imported this test material and, then, only in small quantities. The demand of the Army for over 300 sets of the plates soon exhausted the limited stock in the United States, and further imports were extremely slow in arriving. The situation had become so acute by the summer of 1945 that Dr. Molly R. Harrower-Erickson, a leading research worker in Rorschach technique, had printed a duplicate set of plates which were advanced as substitutes for the original Rorschach designs. These were authorized by the Surgeon General's Office, but did not reach the market until October 1945, too late to meet the peak demand of the field.

SUMMARY

One cannot bring this history of clinical psychology in World War II to a close without expressing appreciation to the men and women who, serving either as enlisted personnel or officers, made it possible for clinical psychology to establish a permanent place in the cooperative program of orthopsychiatry, preventive psychiatry, and combat psychiatry in the U.S. Army. Certain basic lessons were learned that merit consideration for future planning, and these are that—

1. As a result of the efforts of clinical psychologists, sound interpro-

[50] War Department Pamphlet No. 12–9, "Handbook for Clinical Psychologists," 1 Nov. 1944.

fessional working relationships were established, and the best interest of the patients and the service were served when this occurred.

2. Effective working relationships between and among the clinical professions were dependent upon proper orientation, mutual respect, and a sense of self-worth in each practitioner, regardless of the professional field of endeavor.

3. A well-organized plan of training, strengthened by the development of carefully established clinical procedures and a program of implementation by qualified personnel resulted in ready acceptance of the psychologist by the psychiatrist.

4. Careful self-assessment, modesty, and humility, as evidenced by knowing one's own limitations, were assets for the psychologist, which helped him from undertaking more than was warranted by his professional capability.

5. In times of stress, when everyone must carry duties and obligations beyond ordinary competency, the psychologist along with his clinical coworkers in allied fields found the opportunity for growth and development in accordance with intelligence, adaptability, and preparation to meet the new and the unknown. Out of just such experiences, many clinical psychologists and psychological technicians reached new heights of professional attainment and accomplishment.

6. Psychologists, like all other professional workers in the fields of mental health, needed to be flexible yet knowledgeable; to be emphatic, yet aware of the realities; to take pride in their professional competency, yet be capable of maintaining perspective with regard to working with members of all other professions whose responsibilities also encompassed elements of behavior.

Psychology in the Army of World War II has written an illustrious chapter in the Medical Department, especially in relationship to its symbiotic support of neuropsychiatry in the oversea theaters and in Zone of Interior installations.

Once the basic teaching materials were developed, a suitable training environment was established to permit the education of the man in the three R's concurrently or closely paralleling his military training. The mission of the special training units was to prepare linguistically handicapped and mentally limited personnel to carry out their military duties effectively.

Initially, special training units were established in the reception centers. Soon they were moved to the large replacement training centers where the major basic training programs of the Army were being carried out.[51] As a direct result of the increase in industion quotas that allowed up to 10 percent illiterates per day, the War Department granted authority

[51] Seidenfeld, M. A.: Training Linguistically Handicapped and Mentally Limited Personnel in the Military Services. J. Educ. Psychol. 34: 26–34, 1943.

to organize such units in "armies, corps, service commands, divisions, and field units." Up to June 1943, when this program was altered to meet changing points of view, there were 239 special training units in operation.[52]

As Ginzberg and Bray pointed out: "When the selection procedure was altered in June 1943, and illiteracy per se was no longer a bar to induction, a major alteration was introduced into the structure of the special training units * * * they were transformed into an efficient school system." The multiplicity of small units was reduced by establishing 24 large special training units. All these units were in reception centers, permitting the educational program to begin immediately upon admission to the military scene. By this time, men with physical limitations or emotional disturbances were no longer assigned to these units, thus allowing concentration on the linguistically handicapped, educationally deprived, or slow learners.

The procedures employed in the special training units were described by Goldberg.[53] He pointed out that the specific aims of this program were fivefold, as follows:

1. To teach the men to read at a fourth-grade level so that they will be able to comprehend bulletins, written orders and directives, and basic Army publications.
2. To give the men sufficient language skill so that they will be able to use and understand the everyday oral and written language necessary for getting along with officers and men.
3. To teach the men to do number work at a fourth-grade level, so that they could understand their pay accounts and laundry bills, conduct their business in the PX, and perform in other situations requiring arithmetic skill.
4. To facilitate the adjustment of the men to military training and Army life.
5. To enable the men to understand in a general way why it was necessary for the country to fight a war against Germany, Japan, and Italy.

Ginzberg and Bray,[54] in their carefully controlled study of the records of 400 STU assignees in which areas of assignment, color, and time of assignment were controlled, found: "Of the 400 men, 57 (14.5 percent) failed to graduate from STU's. However 6 of these men were withdrawn for defects not considered as related to their mental ability and who under existing regulations should not have been accepted for induction." Of the remaining 51 men, 42 were inept and the remainder received medical discharges for psychiatric problems, enuresis, and the like. Of the 400 men studied, 86 percent were found, during training or upon completion of training, capable of satisfactory performance of duty. Excluding the number discharged for medical reasons, only 7 percent actually failed in STU training.

To further substantiate this result, Ginzberg and Bray[55] studied the

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[52] Ginzberg, Eli, and Bray, Douglas W.: The Uneducated. New York: Columbia University Press, 1953, p. 68.

[53] Goldberg, S.: Psychological Procedures Employed in the Army's Special Training Units. J. Clin. Psychol. 1: 118–125, 1945.

[54] Ginzberg and Bray, *op cit.*, pp. 77–85.

[55] Ginzberg and Bray, *op. cit.*, pp. 94–98.

military effectiveness of the 331 who successfully completed STU training. Their findings are shown in table 64. The classification used indicates that men in the "very good" category attained status of "sergeant and combat decoration or higher"; in the "good," meant "long period in combat and Bronze Star"; in the "acceptable," attained "no higher than PFC and undistinguished"; and in the "not acceptable," was equivalent to "dishonorable discharge, discharge without Honor, et cetera."

Thus, it will be noted that 85 percent of the STU graduates performed at "acceptable" or better levels, as compared to 90 percent of the controls. "Clearly, at a time when the Armed Forces needed men badly, they were able with a small investment to turn many illiterates and poorly educated men into acceptable soldiers."

Seldom has there been a more graphic picture of the successful outcome of a clinical program. Here, the clinical psychologists, the medical specialists, the social services, and the educators linked arms with the military specialist to produce personnel who were capable of rendering effective service during a period when every serviceable man was desperately needed.

TABLE 64.—*Military effectiveness of special training unit graduates and the control group*

Classification	Total		White		Negro	
	STU	Control	STU	Control	STU	Control
	Percent	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
Very good	9	23	12	25	5	20
Good	28	34	35	40	21	26
Acceptable	48	33	41	26	55	42
Not acceptable	12	7	10	5	14	10
Nonchargeable	3	3	2	4	5	2
Total	100	100	100	100	100	100

Source: Ginzberg, Eli, and Bray, Douglas W.: The Uneducated. New York: Columbia University Press, 1953, p. 98.

CHAPTER XX

Psychiatric Social Work

Daniel E. O'Keefe, Ph. D.

Psychiatric social work in World War II was a young and vigorous profession faced with an unprecedented challenge which was met by the skillful and imaginative efforts of its members. Its value to the Army also became sufficiently clear to establish it as one of the professional functions within the Army Medical Department. Psychiatric social work by definition is that social work practiced in direct and responsible relationship with psychiatry in mental hospitals, mental health clinics, and other psychiatric facilities as a part of the activities of a clinical team, which may include psychiatrists, psychologists, psychiatric nurses, occupational therapists, and other professional personnel concerned with the prevention and treatment of mental diseases, behavioral disorders, and other psychological abnormalities.

HISTORICAL NOTE

In 1905, the first psychiatric social workers were employed in neurological clinics, in the Massachusetts General Hospital, Boston, Mass., and in Bellevue Hospital and Cornell Clinic, New York, N.Y. The following year, psychiatric social work was initiated at the Manhattan State Hospital in New York City, by the New York State Charities Aid Association. Here, the psychiatric social worker visited patients' families to obtain collateral information needed by psychiatrists, relative to family background and past life experiences. Later, to the duties of the psychiatric social worker was added the function of preparing families for the return home of mental patients.

When the United States entered World War I, leaders of the psychiatric social work profession foresaw the need for providing care for the mentally ill in Army and Navy hospitals and, in 1918, initiated a training course for psychiatric social work at Smith College, Northampton, Mass. As the flow of neuropsychiatric casualties increased, the Army Medical Department requested the American Red Cross to supply psychiatric social work personnel to military hospitals. The first trained worker was assigned on 1 September 1918, to the U.S. Army General Hospital No. 30, Plattsburg, N.Y., which was established for the treatment of functional neuroses. This worker's duties were to assist the medical officers by

obtaining information regarding the personal, family, and community background of the soldiers under treatment, as an aid in diagnosis, treatment, and plans for aftercare.

After the war, in March 1919, the Surgeon General of the U.S. Public Health Service requested the American Red Cross to organize a social service program within Federal hospitals similar to that already existing in civilian hospitals for mental diseases. The U.S. Public Health Service had been made responsible for the care of veterans. The Red Cross assumed full responsibility for outlining the social service program, formulating policies, recruiting personnel, and assisting in the organization of the work. Because Federal hospitals served large areas, it was essential that the worker be equipped not only to give aid to the psychiatric staff but also to assist local Red Cross chapters in assembling social data, interpreting recommendations for treatment, and helping the discharged patient accomplish the necessary social and other rehabilitative measures for his recovery. Because there was a serious dearth of trained personnel, the Red Cross offered special scholarships and cooperated with existing schools of social work in a program of training. By January 1920, there were social service departments in 42 Federal hospitals. The Red Cross continued to carry the full responsibility for these programs until 1926, when the Veterans' Bureau organized a social work section as a part of its medical services and began taking over the social service programs in veterans' hospitals. The Red Cross continued to maintain departments of social work in 17 Army and Navy hospitals and in St. Elizabeths Hospital, Washington, D.C., during the peacetime interval.

With the exception of a period in 1933, when legislation restricted hospital benefits for veterans, the social work program for military service personnel and veterans continued to expand under the leadership of the Red Cross and the Veterans' Administration.

EARLY EFFORTS

When the expansion of the Army began in 1940 and 1941, the lessons learned at the close of World War I, and subsequently during the days of peace, were forgotten, and social work was not considered an integral part of the military medical organization. Some of the responsibility for this state of affairs must be placed on the field of social work which had established no working relations with any of the branches of the Armed Forces before Pearl Harbor. One indication of the situation was the fact that the National Roster of Scientific and Specialized Personnel of the National Resources Planning Board did not list social work as a profession. Since psychiatry at this time also did not receive adequate recognition within the Army, psychiatric social work had neither leadership nor high level support in the mobilization period of World War II.

Participation of American Red Cross

The early expansion of the medical facilities of the Army and Navy clearly indicated that the psychiatric services would grow rapidly and that the psychiatric social services in the Red Cross program would become increasingly important. Because of obligations imposed by its Congressional Charter, the American Red Cross was committed to provide social work personnel, when such were requested by the Surgeons General of the Army and Navy, to staff the expanding military psychiatric services. In February 1942, a psychiatric social work consultant service was developed by the Red Cross with the purpose of establishing leadership for high standards of psychiatric social work practice in the military program. In June 1942, the Red Cross was requested to assign a psychiatric social worker to the Classification Clinic, Fort Monmouth, N.J., and later, additional requests were received from consultation services in ASF (Army Service Forces), AGF (Army Ground Forces), and AAF (Army Air Forces) training centers. Subsequently, assignment of Red Cross personnel was requested for all medical installations having neuropsychiatric patients, such as Navy hospitals, Army general hospitals, the larger station hospitals, and, later, the convalescent hospitals. Red Cross social work personnel were sent overseas to military hospitals in all theaters of operations. They worked in Army psychiatric centers, in general hospitals, in field hospitals, and on hospital ships returning neuropsychiatric patients to the Zone of Interior.

Role of American Association of Psychiatric Social Workers

After the outbreak of World War II, one of the immediate problems faced by the psychiatric social work profession was the limited number of qualified personnel available for assignment, not only to Red Cross programs but also to the many civilian agencies, hospitals, and clinics which needed the services of psychiatric social workers. The official professional organization of psychiatric social work was the American Association of Psychiatric Social Workers. Among its myriad concerns, at this time, was the need for a centralized Association office which could provide information and leadership in regard to personnel matters.

In September 1942, the Association requested a grant from the Rockefeller Foundation in order to accomplish two major objectives: (1) To centralize data on personnel and vacancies in psychiatric social work and (2) to establish a more vital and immediate relationship with professional education for psychiatric social work. This involved plans for recruiting students for psychiatric social work, for developing scholarship plans to finance students, and for channeling new materials and areas of practice to the schools of social work. It was hoped that such new data might

modify the full 2-year psychiatric social work training program and aid in the preparation of advanced courses for trained and experienced workers.

The Rockefeller Foundation approved funds for this project, and on 19 October 1942, the War Service Office of the American Association of Psychiatric Social Workers was established and continued its operations until 1 December 1945. This office was under the direction of Mrs. Elizabeth H. Ross, the former Secretary of the Association. Through her guidance and leadership, the War Service Office became the central contact point and source of information for social workers in the military services as well as the professional resource from which later the Neuropsychiatry Consultants Division of the SGO (Surgeon General's Office) received much valuable advice in the development of the Army psychiatric social work program.

Among the important early accomplishments of the War Service Office was a survey of membership which was the starting point for many personnel questions and which enabled the Association to establish an accurate accounting of its personnel resources. As an outgrowth of this study which showed that only 35 percent of the membership of the Association were using their specialized training and experience in direct working relationship to psychiatry, it was seen necessary to define psychiatric social work and psychiatric social worker in order to identify clearly the specialty and its practitioners. This definition has been referred to on page 605.

Another important responsibility of the War Service Office was the support which it gave to the various committees of the Association, such as the Advisory Committee to the Red Cross and the War Committee. It also channeled current information to the Committee on Professional Education and to the Publications Committee which enabled these committees, in view of their developing relationships with the war effort, to be aware of the current situation in the field of psychiatric social work.

Liaison with Surgeon General's Office

Shortly after its organization in October 1942, the War Service Office established contact with Col. Roy D. Halloran, MC, Chief Consultant in Neuropsychiatry in the Surgeon General's Office, to inform him that this civilian social work group was willing and anxious to be of assistance to the Army in planning for psychiatric services. An extract from the minutes of the first two interviews held with Colonel Halloran gives the picture of that time:

> Colonel Halloran indicated that the psychiatric casualty rate already was higher than had been anticipated. Under combat it might magnify beyond conceivable proportions. Despite continuing efforts to obtain trained psychiatrists, the Army would not have enough during this war; they did not exist. It would have to draw heavily on all kinds of people who could maximate the usefulness of each psychiatrist: attendants, psychiatric nurses, and social workers, to name some. The Red Cross was pro-

viding excellent psychiatric social workers, but still in relatively small numbers. Moreover, the peak of need was a long way off.

The Psychiatry Branch was anxious to launch a large-scale preventive program through consultation services in training and replacement installations. As a civilian hospital administrator, Colonel Halloran had found social workers of distinct help in caring for patients. But if he were to allocate a large number of social workers, he would put the best and the largest number, in the preventive programs. Hospitals would be his second choice for assignments, and disciplinary barracks third. Even though the expanded consultation program might utilize the experience of the Fort Monmouth Mental Hygiene Unit, and that of existing consultation services elsewhere, such as at Fort Belvoir, Virginia, and Camp Callan, California, no new service was contemplated as being a direct copy of any one unit then in existence.

Cautious doubt was expressed about any chance of success in seeking a classification for Army social workers—as Dr. George S. Stevenson (Medical Director, National Committee for Mental Hygiene) and other psychiatrists had advised. Any new area of Army assignment was sharply suspect, under the best of conditions, and any suggestion which held the possibility of depleting potential combat personnel was triply suspect during a fighting war. To obtain a new classification for enlisted men was severely difficult; to obtain a new classification within the commissioned category was close to impossible. Besides, officer status was far from the first thing to worry about.[1]

Survey of qualified personnel

It was apparent that Colonel Halloran desired evidence that there were enough qualified social workers available to the Army to warrant consideration as to their proper utilization and that quick findings would be extremely helpful. The secretary of the War Service Office, in consultation with a number of persons, such as the military social workers at the Fort Monmouth Mental Hygiene Unit, the staff of the American Association of Psychiatric Social Workers, Dr. George S. Stevenson and Dr. Marion E. Kenworthy, and a number of civilian psychiatric social workers, developed the first tentative standards for social workers. These included professional training in social casework which was considered to be the most desirable social work background needed by Army psychiatry.

On 17 December 1942, the War Service Office requested the graduate schools of social work to supply specific information about all male graduates who had completed a social casework major and whether each man had had courses in social psychiatry and a semester of student fieldwork in a clinic or hospital headed by a psychiatrist. Within a brief period of time, 30 schools of social work had completed and returned their lists of psychiatric social work graduates. Postcard questionnaires were then sent to 200 male casework graduates reported by the schools to have military addresses and to 900 with civilian addresses. The result of this postcard survey indicated an overwhelming interest and desire on the part of social workers, serving in other military assignments where their professional

[1] Ross, Elizabeth H.: Early Efforts of the War Service Office. *In* Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. Henry S. Maas (editor). New York: Columbia University Press, 1951, pp. 180–181.

skills were not being utilized, to be transferred to duties which would be of value in helping their fellow soldiers. Other replies indicated a variety of ways in which social workers were using their skills to some extent in classification or personnel assignments, in special training units, and as assistants to chaplains. These social workers also expressed interest in any appointment, however remote, to work in a psychiatric treatment or mental hygiene program. The evidence which was made available to Colonel Halloran in January 1943 was far more than required, and he launched, then, the first of many steps in a long series which eventually led to the authorized inclusion of soldier-social workers on the staffs of psychiatric services.

EXTENSION OF PSYCHIATRIC SOCIAL WORK

Participation and Consultation Services

In the early days of the war, some social workers with officer status, assigned to classification or personnel work, were utilized in special training programs which had been established to identify the illiterate, non-English speaking, or emotionally disturbed inductees.

As early as mid-1942, in at least two centers (Camp Callan, Calif., and Camp Wallace, Tex.), unofficial but active outpatient neuropsychiatric clinics were functioning with social workers participating in the clinic operations. At Camp Callan, the neuropsychiatrist, Capt. (later Lt. Col.) Julius Schreiber, MC, had developed an outpatient neuropsychiatric clinic which drew its patients from the dispensaries, the guardhouse, the hospitals, the special training battery, the Offices of the Personnel Adjutant and the Personnel Consultant, and other agencies. At Camp Wallace, the Office of the Personnel Consultant, where two psychiatric social workers were assigned (neither classified as a social worker), operated an official mental health service with the personnel consultant acting as the psychologist and the station hospital psychiatrist, Capt. Donald F. Moore, MC, as the director. A considerable number of patients were seen by this unit which functioned informally until early 1943 when the official consultation service was established with its own psychiatric director.

The first formal and completely staffed mental health clinic was developed at Fort Monmouth, where the usual team of psychiatrist, clinical psychologist, and psychiatric social workers functioned in a most effective way and set a pattern for the development of consultation services throughout the Army. This unit was established on 4 March 1942 by Memorandum No. 11, Headquarters, Signal Corps Replacement Training Center, Fort Monmouth, and designated as the Classification Clinic, with a psychiatrist in charge as director. The clinic was made an adjunct of the Office of the Adjutant and, except in those cases where purely medical action was

indicated, operated through that office. The mission of the Classification Clinic was to—

a) institute such corrective measures as are considered appropriate by the Director to reduce or eliminate the individual's maladjustment, eradicate factors related to incipient causes, to adjust the individual to the extent necessary for performance of his duty as a soldier; b) determine by professional methods whether an individual whose case is brought to it for attention is in a group that, gauged by generally accepted practices, either does not utilize his capacity to the fullest possible extent, or is being trained in a skill beyond his capacity; c) recommend for discharge from the service such men who because of mental or emotional factors cannot function adequately or who present a hazard to other men.

In addition to the types of cases just mentioned, men showing indications of mental deficiency were also to be referred for evaluation. On 28 October 1942, Memorandum No. 30, of the same headquarters, established the Classification Clinic as a mental hygiene unit.

It was from the experiences of this clinic that Greving and Rockmore[2] wrote one of the basic papers on psychiatric social work in the Army. Later, on 22 January 1946, at the American Association of Psychiatric Social Workers, New York City branch, Greving[3] concisely summed up the concepts which might be considered unique to military psychiatric social work, as follows:

Social casework services had useful applications in problems of personal adjustment in the military setting. Administrative understanding and leadership were of paramount importance for military psychiatric social workers. Valuable experimentation was possible for the development of many new practices in professional supervision and in teaching. This included attempts to divide the total casework job so as to make possible the maximum service of partly trained individuals and the development of techniques on group methods. Basic casework service had to be adapted to the total military purpose or appropriate fractions of it in order to be effective. It was learned that recording could be consciously modified in length, type and content without losing its professional value, and that taking notes during the interview process did not necessarily curtail the quality of the relationship between the "soldier-client" and the military psychiatric social worker. Each individual military psychiatric social worker and each unit had to arrive at a clear concept of helpfulness which required much more sharpness and specificity than is usually required of civilian agencies. Military psychiatric social workers had a chance to appreciate afresh the significance of brief contacts and small services. The Army gave a new opportunity for demonstrating in practice that social casework skills were independent and separate from the skills and responsibilities of psychiatry.

The Army Air Forces also made use of mental hygiene units, the first one being developed at Drew Field, Tampa, Fla., in April 1943. Its purpose was to serve a group of maladjusted men requiring immediate disposition. Until February 1946, it served about 3,500 air force personnel being drawn from the Third Air Force and from several smaller nearby airbases. The

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[2] Greving, F. T., and Rockmore, M. J.: Psychiatric Casework as a Military Service. Ment. Hyg. 29: 435–506, July 1945.

[3] Greving, F. T.: Group Treatment Potentialities in an Authoritative Setting. Ment. Hyg. 31: 397–408, July 1947.

unit was staffed by a psychiatrist and an average of 10 social workers who had received complete or partial training in schools of social work throughout the country and two Red Cross social workers who were graduate social workers. The history of this unit has been written elsewhere.[4]

Personnel Shortages

As these developments were occurring, it became apparent that social casework practice in the Army was developing as a service to psychiatry and to the soldier-patient. Some of the reasons which contributed to the greater utilization of social workers in military casework assignments were the lack of sufficient psychiatrists; the volume of psychiatric casualties, both actual and anticipated; the limited number of qualified Red Cross social work personnel available; and the excessive cost of maladjusted soldiers, both in terms of economy and morale. The Red Cross made every effort to increase its personnel and, in 1942, developed a program for providing 75 scholarships per year for specialized training in medical and psychiatric social work for persons who had completed the first year of professional training in social work. This scholarship program was expanded until, in 1945, it provided 600 scholarships in schools of social work, a large percentage of which were awarded to students for the first year of their graduate training.

As the War Service Office continued to compile a registration list of qualified psychiatric social workers, there developed efforts to assign social workers to installations where their services could be most effectively used. This was a difficult task for there was no precedent to follow, and psychiatry itself was striving for recognition at the same time. The basic philosophy of military necessity which demanded that all personnel be considered in relation to their usefulness in contributing to the successful prosecution of the war effort forced social workers to prove their value in this light. As they were able to do so, requests for their assignment mushroomed. As an interim measure, lists of misassigned or newly inducted personnel with social work skills, prepared by the War Service Office, were used by the Neuropsychiatry Consultants Division to attempt to fill the needs. The variety of installations which found the contribution of social workers to be of value brought about a need to establish a specification serial number for military psychiatric social workers. Because of the leadership and resourcefulness of Mrs. Ross and the interest of Col. (later Brig. Gen.) William C. Menninger, MC, Chief, Neuropsychiatry Consultants Division, SGO, the detailed problem of establishing this classification was successful.

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[4] Maas, Henry S. (editor): Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. New York: Columbia University Press, 1951, pp. 24–43.

SPECIFICATION SERIAL NUMBER 263 ESTABLISHED

On 23 August 1943, SSN[5] (Specification Serial Number) 263 was designated for enlisted military psychiatric social workers. With this designation, the job of the psychiatric social worker was defined, as follows:

> Under the supervision of a psychiatrist performs psychiatric casework to facilitate diagnosis and treatment of soldiers needing psychiatric guidance; administers psychiatric intake interviews and writes case histories emphasizing factors pertinent to psychiatric diagnosis; carries out mental hygiene prescriptions and records progress to formulate a complete case history; may obtain additional information on soldier's home environment through Red Cross or other agencies to facilitate in post discharge planning; must have knowledge of dynamics of personality structure and development and causes of emotional maladjustment.

The requirements were as follows:

> Should have had at least two years of supervised experience in a public or private agency performing all or a major part of the above (social casework) activities; graduate work with a degree in social work granted by a recognized school of social work will satisfy the experience requirement.

The professional requirements were based on the necessity to define the minimum civilian background which would be safe to establish for soldier-psychiatric social workers assigned to work with psychiatrists and psychiatric patients. It was assumed and anticipated that there would be both psychiatric and psychiatric social work supervision. Along with this assumption, it was desired that individuals assigned to psychiatric social work duties should give evidence of (1) interest in working with people; (2) self-discipline in relation to problems of working with others; (3) desire to work on a professional level; (4) experience in working as part of a social service program; (5) appreciation of the wide range of human behavior; (6) some understanding of motivation and the components of a helping relation; and (7) skill in interviewing people with personal, social, or emotional difficulties. The Army definition, based essentially on job assignment, should not be confused with civilian membership organization standards or the variety of standards that were held elsewhere. This definition and the fact that it was subject to interpretation by classification officers made it inevitable that a very wide range of personnel would be assigned as military psychiatric social workers. A compensatory fact was that this definition was tested in the field by psychiatrists who found an increasing opportunity to compartmentalize the psychiatric social work job and thus utilize personnel who were not completely qualified.

Following the publication of this job definition, many enlisted men were able to obtain assignments which enabled them to use their civilian education and experience in social work. Even this influx of personnel was, however, insufficient to met the rapidly expanding needs of hospitals and

[5] On 18 October 1943, SSN was changed to MOS (Military Occupational Specialty).

FIGURE 52.—T3g. Ellen Sellers, WAC psychiatric social worker, interviewing a neuropsychiatric patient at Brooke General Hospital, Fort Sam Houston, Tex.

consultation clinics for additional social work personnel. It was necessary to institute a recruitment program within the WAC (Women's Army Corps) to obtain more personnel (fig. 52). As the first step, the War Service Office sent out letters of inquiry to schools of social work for information regarding former women students enlisted in the WAC who had fulfilled the training and experience requirements for the SSN 263 classification which had been designated for male military social workers.

On 29 February 1944, WD Circular No. 90, relating to the procurement of female technicians for medical installations, was issued. The alternate requirements for the psychiatric social worker, as stated in this directive, called for either: "a) two years of social work; b) graduation from college with a major in psychology or sociology; c) two years of college with some work in psychology or sociology." These requirements were considerably lower than those for men and caused great concern on the part of professional organizations interested in maintaining the highest standards possible under difficult conditions of shortages of fully qualified personnel.

On 20 June 1944, the standards for WAC personnel were revised

in WD Circular No. 253, and the standards for their qualifications were brought into conformity with those for men.

To provide additional personnel for the incidental services connected with psychiatry and psychiatric social work, a new category was established termed "psychiatric assistants." Persons having only the qualifications originally established for the WAC psychiatric social workers were henceforth designated by this title.

Steps toward locating and reassigning qualified social workers were speeded further by WD Circular No. 295, issued on 13 July 1944. This circular added to the previous official job description by specifying that psychiatric social workers were essential to the proper functioning of the consultation service in training centers and as assistants to neuropsychiatrists in the neuropsychiatric sections of hospitals and hospital annexes in the Zone of Interior. Further, it directed that all personnel qualifying as psychiatric social workers, who were not being properly utilized, would be reported to The Adjutant General for reassignment.

TRAINING

After establishing the SSN 263 classification for psychiatric social workers, in August 1943, educational efforts to improve the quality of military psychiatric social work were concentrated in inservice training courses. The need for such a program developed spontaneously in hospitals and consultation services where military personnel were assigned to duty as social workers. Because of the critical shortage of fully qualified psychiatric social workers, it was necessary to lower the minimum qualifications to a level which included 2 years of supervised experience in a social agency as acceptable. This meant that instead of graduate social workers with a major in psychiatric social work, the Army was forced to use persons who had no professional education and little or no knowledge in handling patients with psychiatric difficulties.

Military Inservice Training

Psychiatrists and qualified social workers had realized the training deficiencies in the variety of social work personnel in the service and, in order to raise the standards of efficient service to patients, had instituted training courses. For instance, at Camp Carson Convalescent Hospital, Colo., the inservice training program for social workers was considered to be the responsibility of the casework supervisor and his assistants. It had as its objective the development of each social worker in general skills and concepts, which would enable him to handle a wide variety of patients skillfully, and also the improvement of specific methods of handling each

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individual patient to insure maximum help to that patient. The program included the following methods:[6]

1. Prescribed introductory courses and seminars in which basic concepts of psychiatry and psychiatric social casework will be presented. The responsibility of the content and conduct of this phase of training will be delegated to the casework supervisor and to the psychiatrist.

2. Individual conference between social worker and his own supervisor. These conferences will be held at least once a week and will include discussion of individual cases, general principles of casework, group work and psychiatry and the application of these principles to individual case situations. The responsibility for the content and direction of these conferences will be shared between the supervisor and the individual social worker. The individual social worker will be expected to make maximum use of these conferences by keeping himself aware of his need for professional development.

3. Conferences of all social workers supervised by one supervisor. These conferences will be held weekly to discuss administrative matters and to encourage uniform development of professional skills and understanding among the staff. Common treatment problems can be discussed here. The responsibility for content and conduct of these courses will be that of the individual supervisor.

4. Social Work Staff Conference. This conference will be held weekly and all members of the social service staff will attend. The content will include any matter professional or administrative that the staff believes is pertinent. The responsibility for the content and administration of these conferences will be that of a committee of social workers. All social workers will be expected to contribute to these conferences.

Another social work inservice training program at Welch Convalescent Hospital in Daytona Beach, Fla., was organized on the basis of semiweekly meetings. The chief of the Neuropsychiatric Treatment Branch gave the general orientation which had, as its content, the following:[7]

a) Purpose of an inservice training program within the unit; b) orientation to social work in an Army hospital setting; and c) administrative setup of this psychiatric unit.

The second section of the program was devoted to the "Dynamics of Human Behavior," taught by psychiatrists and encompassed the following content: The Normal Psychology of the Development of Personality; Basic Concepts of Abnormal Psychology; Psychopathology for Psychiatric Social Workers; Social and Psychiatric Implications of Illness; Implications of Illness in the Army—the Meaning of Symptoms; Military Psychiatry; and Cultural Problems as They Affect the Individual.

The third section was "Fundamentals of Social Case Work," taught by social workers: The Meaning of Social Case Work—Basic Concepts; Case Work Differentiated From Psychiatric Treatment; Review of Current Literature; Basic Case Work Literature; History Taking As An Aid To Diagnosis; Treatment Methods in Case Work; Principles of Case Work Interviewing; Case Work As An Aid to Diagnosis; Case Work and Group Work Methods; and Group Psychotherapy. Each of these lectures was followed by a review of current literature.

The fourth section defined the "Role of the Social Worker in this Convalescent Hospital": The Soldier in the Army—His Problems, Adjustments, Anxieties, Normal vs Abnormal Reactions; Original Contacts With the Soldier at Intake; Social Work Responsibilities; Group Psychotherapy on the Company Level; Case Work Contacts on the Company Level; The Use of Army Resources in Treatment Process and in

[6] Personal communication to author.
[7] Personal communication to author.

Diagnosis; Classification and Assignment a Problem in Treatment; Administrative Problems of the Psychiatric Social Worker; and Methods of Recording the Case History.

The final section was devoted to "Team Relationships": The Role of the Psychiatrist in the Clinical Team; The Role of the Psychologist in the Clinical Team; The Role of the Social Worker in the Clinical Team; The Function of the Red Cross in the Hospital Unit; and, finally, Summary of In-Service Programs.

There were many facilities, such as the Mental Health Unit at Drew Field, where training was early established for Third Air Force personnel and at the Second Air Corps Training Center where all 289 mental health personnel assigned to consultation centers were trained under a psychiatrist and a psychiatric social worker and an exceptionally good job was done.

The experiences of the Fort Monmouth Mental Health Unit had progressed so far that, in July 1943, the staff there proposed a tentative program for on-the-job training. Their experiences, together with those of Camp Carson, Colo., Camp Edwards, Mass., Camp Butner, N.C., Welch Convalescent Hospital, Daytona Beach, Fla., Percy Jones Convalescent Hospital, Battle Creek, Mich., and Mason General Hospital, Brentwood, Long Island, N.Y., were all used to develop a formalized training program. It was planned to organize training courses in the winter of 1944 which would be established at two centers, one in the East and the other in the West, which would meet the needs of the field. Mrs. Ross was commissioned to prepare the necessary material, which she did with the assistance of Maj. (later Lt. Col.) Manfred S. Guttmacher, MC. The goal of this program was to include the necessary orientation to psychiatry with adequate social casework orientation and on-the-job training. A plan was recommended to the Training Division, SGO, proposing that this course be established at Mason General Hospital and Camp Carson Convalescent Hospital. Approval was granted, but the cessation of hostilities made necessary the termination of these plans.

Because it was the opinion of the Neuropsychiatry Consultants Division that this material had considerable value, it was decided to revise the plans for the presentation of the course and make it available to all installations where social workers were assigned. Accordingly, the material was mimeographed and sent out to the neuropsychiatric consultants in the various service commands for them to distribute to the installations where they thought it would be helpful. The following subjects were outlined in the final draft:

I. Practices in military psychiatric social work:

a. Interviewing.—To present the principles, purposes and practices of psychiatric casework interviewing in a military setting and to delineate the responsibility of the interviewer to interpret the scope and facilities of the neuropsychiatric service. To emphasize his obligation to make the interview purposeful and meaningful to the patient and his delegated authority to seek information, to observe attitudes and to note behavior which would aid the unit in its specified psychiatric function.

b. Interpretation.—Responsibilities and factors of military relationship between individual psychiatric social workers representing their neuropsychiatric unit and other Army personnel who are carrying some responsibility for soldier patients.

c. Administration.—Administrative structure of the neuropsychiatric unit and of the installation. Army policies and procedures and regulations affecting the practice of military psychiatric social work.

d. Resources available to military psychiatric social workers.—The purpose, provisions and administrative structure of technical services and specialists skills in related programs for unadjusted soldiers and soldier-patients.

II. Functional relationship to military psychiatry:

a. Personality structure and function.—To discuss the standards, development and behavior by which soldiers are considered, in Army terms, to be "well adjusted." To describe the stages in adaption to military experience from induction through discharge; mechanisms by which behavior is an expression of unconscious as well as conscious motivation; and the selective predisposing physiological, cultural, biological and social factors which account for individual difference and group alikeness.

b. Psychopathology for psychiatric social work personnel.—To present the extent and limitation of psychiatric social work duties in relation to psychiatric responsibilities for determining psychopathology within Army policy; to discuss origins, meanings, adaptive purposes and effects on the personality of the major psychoses and neuroses; physiological involvements; extent to which symptoms represent exaggeration of health responses; organic neurological changes resulting from nerve injuries. Military and social importance of the concept of psychoneurotic reaction to stress; types of mental character deficiency; diagnostic aids, significance of diagnosis and responsibility of military psychiatry for treatment.

c. Orientation to Army psychiatry.—To study the functions and administrative relation of psychiatry within Army medicine and in relation to Army purposes. Psychiatric responsibility for the study and/or treatment and recommendation on possible cases of mental illness and emotional disturbances, of mental deficiency, chronic alcoholism, psychopathic or criminally inclined personality, malingering; problems of discipline, morale and other functions of the command as they affect the individual and the military organization.

d. Group therapy.—Survey of group therapy as a psychiatric function; the purpose, general scope and practice within military psychiatry; the function of the military psychiatric social worker as a group therapist working under psychiatric supervision.

III. Functional relationship to clinical psychology:

To discuss the types and purposes of commonly used individual and group tests of intelligence, aptitude and personality evaluation as administered in neuropsychiatric units in the Army and to observe their administration.

IV. Functional relationship to classification, assignment and separation:

Survey of the purpose, methods and procedures of military classification and assignment. Interpretation of Adjutant General Form No. 20, discussion of the current policies concerning the assignment of general, limited-service, and ex-combat personnel; practical implication of classification responsibilities during redeployment and of the point system and planned discharge.

Red Cross Inservice Training

To meet the growing requests for personnel, the Red Cross instituted an inservice training program of broad scope. This program included, as one of its particular aims, the development of projects for giving specific training or orientation in working with neuropsychiatric patients to social workers who had had no specialized training or experience in psychiatric social work. One such project was developed at the Army Air Forces Convalescent Hospital, Fort Logan, Colo. Another project was developed

at St. Elizabeths Hospital, Washington, D.C., in which the emphasis was placed on training the hospital worker or staff aid group to render specific services to neuropsychiatric patients. Other training centers were developed within the five areas of the Red Cross to give, on a smaller scale, this type of orientation to workers.

STANDARDS OF PRACTICE

As military social work developed, no attempt had been made to standardize its practice. Therefore, to correct this situation, General Menninger directed Mrs. Ross to prepare a suitable guide for the social work specialty. Mrs. Ross's knowledge of casework skills and her detailed contacts with a large number of military social workers, in her capacity as Secretary of the War Service Office, made her admirably qualified to assume this responsibility. She worked in close cooperation with Major Guttmacher and General Menninger and prepared the first official document on military psychiatric social work practice. This was published as TB MED 154, "Psychiatric Social Work," and issued in June 1945.

TB MED 154 was intended to serve as a guide for military psychiatric social workers and psychiatric assistants, outlining their administrative relationships and professional duties. It also outlined the orientation of psychiatrists, classification officers, and other relevant military personnel relative to the qualifications of various types of social work personnel and their practice in this field.

The duties of military social workers covered specific social services "which should be delegated by the neuropsychiatrists" and included the following:

1) Obtains information from Army units; presents history of material or interview content for the neuropsychiatrist, so that diagnoses, treatment and disposition are facilitated. 2) Will, under the direction of the psychiatrist, interpret the findings and/or the program of the psychiatric unit to agencies or persons concerned, such as, other medical personnel, unit commanders. 3) Will have the responsibility to explore and initiate effective use of opportunities and facilities within the Army structure, to aid in the solution of the patient's problem. 4) Aids in the reorientation of the soldier to his problem, making such recommendations for, and reports of, treatment and disposition to the psychiatrist as may be pertinent and possible. 5) Will assist, when directed, with group therapy, preventive psychiatry, or other programs for which the neuropsychiatrist is responsible. 6) Will aid in administrative procedures, including the preparation of necessary records, and reports, schedules, and other related activities.

The duties of psychiatric assistants were also defined and were as follows:

1) The selection and preparation of objective data related to patients, such as abstracting accessible medical and nonmedical records, maintaining records of psychiatric service, etc. 2) Delegated aspects of the administrative responsibilities of the psychiatrist, such as initiation of certificate of disability discharge forms, reports to Boards of Officers under AR 615–368 and AR 615–369.

A warning was given that psychiatric assistants would not be assigned to the duties requiring direct contact with patients without providing adequate safeguards to patients by close supervision. This restriction was considered necessary because frequently, under the heavy pressure of large caseloads, additional personnel, less qualified, had to be used by the psychiatric units. For the improvement of these personnel, TB MED 154 stated:

> Individuals with minimum qualifications for SSN 263 show a wide variation in these qualifications in their professional education as well as civilian experience. Their competency will therefore vary widely * * *. Many military psychiatric social workers have had no experience in psychiatric organizations prior to their Army experience. Among social workers will be found not only psychiatric social case workers and social case workers, but also personnel especially trained in social group work, social administration, community organization, and social research. Standards for the selection and assignment of military psychiatric social workers must be based on Army needs and policy; and, of necessity, these will require readjustments of civilian professional standards. A continuous on-the-job training program of lectures and seminars, particularly to orient the new worker, will contribute greatly to efficient service.

CONVALESCENT HOSPITALS

In 1944, the return of patients from overseas caused an acute shortage of medical and surgical beds. This lack of bed space coincided with the recognition that the neurotic patients did poorly when treated at general hospitals. These facts forced the establishment of convalescent hospitals and again increased the demand for psychiatric social workers. The need for these workers was so severe that psychiatric social workers were placed in a category of critically needed personnel.[8]

Twelve convalescent hospitals were established throughout the United States, to which approximately 50 percent of the psychoneurotic casualties were assigned. The overall and basic psychiatric aspects of the convalescent hospital program were integrated through the training courses provided by the neuropsychiatric training officer for general medical officers, social workers, psychologists, and other personnel. Considerable leeway, however, was given to the company commanders in their individual practice of psychotherapy. The psychologists were usually assigned to the battalion headquarters, and the social workers were assigned to the individual companies. Whitney,[9] who had been assigned to the Fort Story Convalescent Hospital, Va., evaluated this experience as follows:

> The presence of military psychiatric social workers enabled the five psychiatrists assigned to the group of 600 patients in the Neuropsychiatric Battalion to put into effect a psychotherapeutic program designed to afford the maximum possible benefit of treatment to each patient in the six- to eight-week period. No patient could go

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[8] War Department Memorandum No. W615–44, 29 May 1944.

[9] Whitney, Forrest H.: Convalescent Hospital. *In* Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. Henry S. Maas (editor). New York: Columbia University Press, 1951, pp. 97–98.

unknown or unrecognized throughout his hospitalization, as he felt had so often happened previously. The workers usually carried a caseload of 20 to 30 patients, although occasionally the number reached 50. Each patient was offered a continuing relationship with a caseworker who was fully identified with the psychotherapeutic goals of the hospital. Thus, the patients had the opportunity to regain some security and strengthen their self-confidence which had been shaken by recent military experiences.

The social workers themselves found new satisfactions in their military experience. They used and deepened their skills in helping patients who, like the social workers, were a part of the gigantic war effort, but who had lost their capacity to be useful to themselves and to the military service. The social workers who had not previously worked in a psychiatric setting gained through training and experience knowledge about types of cases not known to nonmedical social agencies. All social workers found valuable their experiences in the technique of group psychotherapy which embodied the principles of individual treatment and speeded up some of the processes essential to enabling patients to use help. Living in the barracks afforded the social workers an opportunity to observe patients in their daily activities and relationships with many of the people in the hospital setting. However, the fact that the social workers were also barracks leaders, a result of the attempt to make maximum use of limited manpower, sometimes had the effect of draining the social workers' energy and carried the seeds of negative countertransference which had to be watched for continuously.

Although some social workers found for the first time that psychiatrists do not necessarily have all the answers for treatment of all patients, they appreciated the doctor's assumption of responsibility for decision on the disposition of each case. Basic to the entire program was the feeling of unity which the staff achieved through striving together for therapeutic goals and through providing one another with emotional support through the process of attaining those goals. This unity compensated for the pressures which were sometimes felt as a result of trying to be both a soldier and a professional social worker.

At the Camp Carson Convalescent Hospital, the specific functions of psychiatric social workers were defined as follows:[10]

1. Intake Study.—This will consist of the history taking, initial discussion with patients of the manner they used at illness in their efforts to adjust, clarification with the patient with what he considers to be his adjustment difficulties and adjustment needs, stimulation of the patient's awareness of his own role in his recovery, and interpretation of the facilities of the program in terms of the patient's awareness of need. The interpretation will include explanation of services offered by the psychiatrist, psychologist, and group therapist.

2. Social Service Treatment.—This will consist of scheduled appointments arranged insofar as possible with the active participation of the patient. The social workers are not encouraged to initiate discussion of symptoms in these interviews but to handle such discussion of symptoms as the patient may bring up in such a way as to help the patient use the psychiatrist for the treatment of symptoms. The social worker is encouraged to discuss with the patient how he is using the facilities, to recognize the emergence of positive interest and strength in the patient and particularly to assist the patient in making the daily small decisions that confront him. Detailed discussion of past painful experiences are not usually helpful in short term therapy, consequently the social workers will focus the discussion on current matters, future plans, and, if necessary, on the contrast between recent experiences which precipitated illness and their present situation which enabled the patients to give up illness. Social service

[10] Personal communication to author.

treatment will also include helping the patient recognize his need for psychiatric help. This is particularly true when patients find themselves incapable of making daily decisions, or become easily upset and constantly bring up symptoms with no improvement.

3. Referrals.—All referrals will be made on the basis of recognized needs for the referral by the patient. Discussion will precede a referral to enable the patient to accept the benefits that are expected to accrue from the referral. Each referral shall be followed up to determine if the expected benefit actually accrued.

4. Group Therapy.—Social workers who are capable of conducting group therapy will be afforded the opportunity to do so. The methods and goals in group therapy will be those that the psychiatrists decide shall be uniform for the clinical section. As a rule, it is expected that the content of group therapy discussions conducted by social workers will differ from those conducted by psychiatrists and psychologists since the social workers are specialized in evaluating social situations. Consequently it is likely that detailed discussion of anatomy, psychosomatic mechanisms, symptoms per se, etc., will be kept to a minimum and patients bringing these matters up for discussion should be advised to discuss them with the psychiatrists. However, such matters should not be completely avoided for brief, nontechnical discussion can help the patients understand their conditions and put this understanding to constructive use.

GENERAL AND SPECIAL HOSPITALS

As the pace of combat quickened, both Red Cross and military psychiatric social workers found new and different uses for their skills and learned to function in very different kinds of settings.

Overseas

Miss Irene Tobias,[11] a psychiatric social worker of the American Red Cross, described her experiences in a general hospital during the Tunisia Campaign and, later, in a neuropsychiatric hospital, as follows:

In this setting of a military hospital overseas, the social worker had to function in a medium unlike anything for which her previous experience had prepared her. The usual physical setup and equipment were nonexistent. Elements of distance and difficulties of communication separated her from the accustomed, supporting close presence of an agency and supervision. Far away were the traditional aids of family and social resources. Functioning was severely limited by the short association with patients and by the pressure of the job. The casework tools—understanding and skill—stood pretty much alone and in these situations were put to a severe test of usefulness. But I do not think it can be doubted that at least the simple and concrete steps of casework can be used everywhere in military settings. The greater part of casework in any setting consists of these simple steps.

The objectives of the job were set by the Army. They were to help the sick or wounded to return to duty faster, or, if the soldier was to be discharged from the army, to help him become a more productive citizen. If the setting presented difficulties and frustrations, the rewards were commensurate. The traditional function of the social worker in helping the individual now coincided with helping to win the war. No social worker could ask for a greater opportunity.

Overseas the job called for more than professional skills. It called for the involve-

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[11] Tobias, Irene: A Psychiatric Social Worker Overseas. Family Welfare Association of America, 1945, p. 45. [Pamphlet.]

ment of the total personality. The professional and personal self became integrated in the adaptations made in entering overseas service. There were adaptations to be made in the mode of living, in the giving up of privacy, in changing tastes in food, in adjusting to military discipline and the consequent curtailment of personal freedom. All this became symbolized in putting on the Red Cross uniform which the Army never allowed to be taken off for any occasion while the worker was overseas. Out of this pool of adaptations came a sense of freedom of becoming oriented to this strange new world. Out of it, too, came a sense of extended range of capacities.

In this setting and confronted by the pressure of so many human needs, we did whatever we could, employing the total range of personal capacities.

Zone of Interior

Not only were Red Cross social workers involved in experiences similar to the ones described by Miss Tobias, but they often worked side by side with military psychiatric social workers. One example, described by Greenberg,[12] was at the Mason General Hospital which was a 3,000-bed hospital, equipped for the treatment of soldiers suffering from various types of psychiatric illnesses:

The hospital staff consisted * * * of the doctors, nurses, attendants, psychologists, social workers, physical therapists, and other staff specialists who were mostly Army personnel, either in the enlisted or officer categories, but the social service unit consisted of both military and Red Cross social workers. All were assigned to specific wards and were responsible for the same areas of service. This administrative arrangement was made with the concurrence of the Red Cross Field Director.

The military social workers were all enlisted men and women, ranking from private to master sergeant. As was the case in other Army units, the social workers in Mason General Hospital ranged from those who had complete training and extensive civilian experience to those who had had no training and what, at best, could be considered only a dubious professional experience. None of the military social workers came with any social work experience in a civilian psychiatric hospital. A few had worked with psychiatrists before coming into the Army. For most of the workers, psychiatric terminology, concepts, and understanding had to be developed. For all of them, the true meaning of psychiatric social work in the Army—the real meaning of being a soldier social worker to other soldiers—was frequently elusive and often perplexing.

Deep sincerity and a desire to develop a practice which would be professionally acceptable and ultimately of greatest helpfulness to the soldier-patients characterized the day-to-day job of the military social workers [at Mason General Hospital].

[In this hospital], the total role of the social worker as conceived and developed * * * was predicated upon two facts: (1) the essential mission of the hospital was to diagnose and make disposition of all admitted patients as quickly as possible; and (2) the period between the patient's admission and eventual discharge carried for him many problems inextricably interwoven in his being a patient in a mental hospital.

The total job [of the social work staff] was broken down into five major responsibilities: 1) Orientation of new patients; 2) interviewing for a social case history; 3) continued service in relation to the patient's ward adjustment; 4) planning with the patient for his discharge; and 5) interpretation to relatives.

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[12] Greenberg, Irving: Neuropsychiatric Hospital. *In* Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. Henry S. Maas (editor). New York: Columbia University Press, 1951, pp. 63–67.

Mr. Greenberg summarized some of his impressions of his experience at Mason General Hospital in the following way:

The definition of what the social worker did and how the social service job was accomplished could not always be interpreted adequately to the entire medical staff. Those ward physicians who continued in the hospital as social service "grew up" learned for the most part what was clearly within the social worker's province and what was not. Unfortunately, what was true for any Army installation was true for Mason General Hospital, namely, rapid turnover in staff doctors. Individual social workers on the wards had to do the interpreting, the clarifying, and the eventual interlocking. Only toward the latter period at the hospital was there a systematic and regular presentation of social work as a fundamental discipline, with specific areas of responsibility in the overall treatment of neuropsychiatric patients. A review of this experience in an Army neuropsychiatric hospital leads to the following generalizations: .1) The military psychiatric social worker has to develop his own concept of practice; 2) he is at first completely dependent upon the prior experiences and basic confidence which psychiatrists on the staff have in utilizing social workers. As he goes on, he can begin to rely with greater security on that which he has created; 3) the social worker has to come to terms with the fact that the mission and needs of the Army are primary, and that the needs of the patient as an individual can be appraised and met only with reference to the Army's needs; 4) when the social worker defines his job and his purpose in clear terms for the Army and its hospital and then for the patient whom he serves, his contribution as a distinct professional person begins to have meaning; 5) the social worker can with dignity and professional value remain a social worker without having to cross into the realm of psychotherapy.

MISCELLANEOUS ACTIVITIES

Disciplinary Barracks

In addition to installations already mentioned, psychiatric social workers functioned in other activities; for example, the disciplinary barracks which were in operation beginning in 1942. Initially, the tables of organization for disciplinary barracks included a psychiatrist; later, a clinical psychologist and one or more psychiatric social workers were authorized. Menninger [13] has pointed out that one of the gratifying contributions of psychiatry was the initiation of treatment in almost every correctional installation. In these efforts, the psychiatrists were assisted by their colleagues, including psychiatric social workers. One example was the Milwaukee Disciplinary Barracks where over a thousand prisoners were received. At this installation, there were two psychiatrists, two clinical psychologists, and three social workers. The social workers were responsible for the initial interview of all prisoners. Then, after a classification procedure (pp. 503–506) which established the prisoner's treatment and rehabilitation program, social workers participated in the counseling program for prisoners who showed problems of maladjustment. These workers also participated in a group therapy program.

[13] Menninger, William C.: Phychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, pp. 197–201.

Another procedure which was the responsibility of the social workers was to interview prisoners 2 months before their release in order to help them work out discharge plans. Social workers also utilized the facilities of the American Red Cross to establish liaison with community agencies in order to assist the prisoner after he was discharged.[14]

Combat Divisions

A second unique use of a few social workers was their assignment to divisions to assist the division psychiatrists.[15] These men screened combat casualties and, in collaboration with the psychiatrist, determined whether the individual soldier could be restored to duty after a comparatively brief rest period or whether he would have to be evacuated from the combat zone for more intensive treatment. While these assignments were quite limited, they did form a pattern which came to be useful in the Korean War.

Liaison

In the coordinated teamwork between the American Red Cross and the Neuropsychiatry Consultants Division, a new development occurred in August 1944 when the Red Cross was requested to assign large numbers of psychiatric social workers to the neuropsychiatric reconditioning program. General Menninger described the goals of this program and emphasized the urgent need for and contribution to be made by psychiatrically trained social work personnel. To meet more adequately the needs in this program, as well as those in other treatment centers for patients with special disabilities, the Red Cross table of organization was revised in September 1944. A large proportion of the staff approved and budgeted for in convalescent hospitals was designated for psychiatric patients.

In accordance with Red Cross agreements with the War Department, psychiatric social workers participated at the request of psychiatrists in research and special studies. At the request of General Menninger, a psychiatric social worker was assigned to the Neuropsychiatry Consultants Division for a period of a year to assist in a followup study of psychoneurotic patients.[16]

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[14] Brodsky, Irving: Disciplinary Barracks. *In* Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. Henry S. Maas (editor). New York: Columbia University Press, 1951, pp. 99–117.

[15] The employment of social workers in divisions, Army "exhaustion centers," and hospitals overseas cannot be documented. They were utilized by psychiatrists, when available. Almost all were enlisted personnel who were performing other functions, and their assignment was a chance phenomenon or based upon their presence in a particular area at a particular time. Not all were fully trained. Most had only partial training and experience.—A. J. G.

[16] Brill, N. Q., Tate, M. C., and Menninger, W. C.: Enlisted Men Discharged From the Army Because of Psychoneuroses; Followup Studies. J.A.M.A. 128: 633–637, 30 June 1945.

PSYCHIATRIC SOCIAL WORK BRANCH, SURGEON GENERAL'S OFFICE

As early as 1942, military personnel on active duty, both psychiatrists and psychiatric social workers, had been in correspondence with the Neuropsychiatry Branch, SGO, seeking assistance in establishing programs which involved the use of psychiatric social workers. It was hoped that from the Surgeon General's Office would come the direction and planning which would enable psychiatric social work to achieve a more responsible position in the various psychiatric activities which were being undertaken in the Army medical program.

In 1943, when General Menninger became Chief Psychiatric Consultant to The Surgeon General, he made intensive efforts, with the assistance of the War Service Office and the cooperation of the National Committee for Mental Hygiene, to develop a position for a chief social worker to be assigned to the staff of the Neuropsychiatry Consultants Division. On 1 July 1945, after 2½ years of effort, the Psychiatric Social Work Branch was established in the Neuropsychiatry Consultants Division. This author was assigned as the first chief of this newly created branch.

Proposed functions.—The chief of the Psychiatric Social Work Branch was given wide latitude for the use of independent professional judgment. He was considered a consultant and adviser to professional medical personnel in the Office of The Surgeon General and in Army installations, with the responsibility of advising, developing, and directing the social work program for The Surgeon General. He was to participate in the planning of preventive mental hygiene programs for troops in varied settings and activities where social work skills might aid in the promotion of morale or efficiency of the troops. He was made responsible for the development and standardization of methods and materials used in the practice of psychiatric social work in the Army. In this regard, he was free to consult with professional organizations and public and private associations in order to provide adaptations of such civilian social casework practice as were appropriate to improve Army practices. He was to establish methods of practice and to modify, adapt, and implement the military social work program for a wide variety of military personnel, including neuropsychiatric casualties, prisoners, and maladjusted soldiers. Further, he was to act in a liaison capacity with the chief of the Neuropsychiatry Consultants Division and the American Red Cross social work program.

Hutt and his associates,[17] in a footnote to "The Neuropsychiatric Team in the U.S. Army," stated:

> The team concept was applied not only in the field, but in the Surgeon General's

[17] Hutt, M. L., Menninger, W. C., and O'Keefe, D. E.: Neuropsychiatric Team in the U.S. Army. Ment. Hyg. 31: 103–119, January 1947.

Office, War Department, as well. From July 1945 on, within the Neuropsychiatry Consultants Division, Surgeon General's Office, such a team, directed by a psychiatrist, included a chief of the clinical psychology branch and a chief of the psychiatric social work branch. These demonstrated in their daily program of work, in their planning, direction, and supervision of the Army psychiatric program, the smooth and effective functioning of the neuropsychiatric team in this high Army echelon. This organization resulted from much previous ground work and long range planning.

In terms of working relationships, each of the branch chiefs in the Neuropsychiatry Consultants Division was delegated the authority to operate his program and was always assured of the support of the director of the Division. At a daily staff meeting, each branch chief would briefly outline his activities and plans for that particular day so that all the staff members were cognizant of the status of plans and projects which each was undertaking. Once a week, a large staff meeting was held at which representatives of the Army Ground Forces, the Army Air Forces, and the American Red Cross would discuss the activities and interests of the various phases of the Army psychiatry program. In this way, those corollary agencies which were also interested in the broad aspects of the total psychiatric program for military personnel were kept aware of the plans and activities being carried on in the Neuropsychiatry Consultants Division. If an individual staff member needed aid to expedite certain phases of a project, he was always free to call on other staff members for assistance. For instance, when efforts were being made to develop adequate rosters of social work personnel on duty, it was the psychiatrist in charge of personnel who facilitated the acquisition of this information. Such cooperation was always available and readily given. Also, Mrs. Ross had been appointed as a civilian consultant and her services were likewise available and were frequently used.

OFFICER PSYCHIATRIC SOCIAL WORKERS

Although efforts had been made to obtain officer status for social workers throughout the war, this effort was not successful until after the termination of hostilities. During the war, a few social workers had been commissioned as clinical psychologists, because the original qualifications for this specialty accepted social casework as a qualifying experience. Some of these officers were able to function as social workers in particular situations, while others were assigned only to psychological duties. Later, qualifications for clinical psychology became more restrictive.

On 8 February 1946, with the issuance of War Department TM (Technical Manual) No. 12–406, MOS 3605 was established for the position of "Military Psychiatric Social Work Officer." The duties and qualifications for this position were as follows:

Directs or supervises the psychiatric social work in a hospital or clinic. Develops a social service program and establishes social work policies under supervision of the

psychiatrist; assists psychiatrists in the coordination of the social work activities with those of the clinical psychologist, the Red Cross, and related services; supervises through the reading of records and conferences, the social casework activities of the enlisted psychiatric social workers; plans, with the psychiatrist, on-the-job training for psychiatric social workers and for psychiatric assistants and takes part in appropriate instructions; undertakes social work treatment of such special cases as may be assigned by the psychiatrist.

Must have completed academic requirements and supervised field work in an accredited school of social work, with a major in psychiatric social work; or have completed academic requirements and supervised field work in an accredited school of social work, with a major in social casework, plus at least six months supervised experience in a psychiatric agency.

On 29 December 1945, with the issuance of WD Circular No. 392, psychiatric social work was included as one of the specialties in the Pharmacy Corps of the Medical Department, and announcement was made of the opportunities for appointment in the Regular Army for such individuals who had held commissioned status during the war. This was a step forward in progress but did not provide opportunities for commissions to those enlisted men who had the required qualifications. With the publication of TM 12–406, which defined the qualifications of officer psychiatric social workers, personnel qualified in this specialty were eligible for commissioned status.

To enable qualified personnel to obtain commissions, a request was forwarded by The Surgeon General to the Reserve Officers' Branch, Adjutant General's Office, in January 1946, asking that consideration be given to the establishment of a section within the Reserve component for qualified psychiatric social workers.

STATISTICS

Throughout the war, one of the major difficulties was to maintain a current roster of the assigned psychiatric social workers. One chief reason for this problem was the lack, for a long time, of a classification serial number for social workers. Another reason was that persons having social work qualifications were classified under other specification serial numbers such as SSN 289, Personnel Consultant's Assistant, and SSN 275, Classification Specialist. In the Army Air Forces, all social workers were classified as SSN 289, Medical, until 18 August 1945. Because the definition of psychiatric social worker contained the qualifying phrase "should have the following experience" instead of "must have," it developed that many persons were classified as SSN 263, who were qualified by military experience only—an unknown but large group.

In February 1945, the Resources Analysis Division, SGO, obtained a report on the number of psychiatric social workers assigned to ASF installations. This report noted that psychiatric social workers were not included on the reporting form, 8–19, by the following hospitals: Station

Hospital, Camp Edwards; Valley Forge General Hospital, Phoenixville, Pa.; Darnall General Hospital, Danville, Ky.; Thomas M. England General Hospital, Atlantic City, N.J.; Wakeman General Hospital, Camp Atterbury, Ind.; and Mitchell Convalescent Hospital, Campo, Calif. This group of hospitals, each with a large neuropsychiatric service, probably utilized between 75 and 100 personnel with the MOS 263 classification. Other installations reported 290 assigned psychiatric social workers. Combining the reported group with the unreported one, it was assumed that approximately 400 persons were engaged in social work duties in ASF installations. These figures did not include the psychiatric assistants. By another survey, the number of Wacs so assigned was estimated to be 247. This total of 647, in turn, was not comprehensive because psychiatric social workers and psychiatric assistants were also utilized in the Army Air Forces and Army Ground Forces, but statistical data from these echelons could not be obtained. A small group of psychiatric social workers was known to be functioning in oversea installations but actual count was impossible. Their number was probably less than 25.

In August 1945, another count of the ASF installations revealed that approximately 711 persons were classified and assigned as psychiatric social workers or psychiatric assistants. At this time, also, no information was available from Army Air Forces, Army Ground Forces, and oversea installations.

While these figures were not accurate, certain facts and trends could be extracted. Social workers were concentrated in general and convalescent hospitals. Consultation services (Mental Hygiene Consultation Services) were generally adequately staffed in the ratio set forth in TB MED 156 which stated there should be 1 psychiatric social worker for each 3,000 trainees. A shift of social work personnel from neuropsychiatric sections of station hospitals to the reconditioning facilities was noted when these were established. A small but increasing number of social workers were assigned to rehabilitation centers and disciplinary barracks. Only a handful of social workers functioned as assistants to division psychiatrists, but their services were considered to be of great value. There were no known assignments to redistribution centers or induction centers in the report of August 1945. It is interesting to note that at this time, when the greatest number of personnel were assigned to social work duties, the Military Personnel Division, SGO, had, on hand, requisitions for 201 enlisted male social workers and 4 psychiatric assistants. WAC recruiting had terminated, or there might have been additional requests for these personnel. In view of the difficulties which beset the program of establishing psychiatric social work in the Army, this accounting of the filled and unfilled positions, numbering approximately 1,000, is an index of the high value placed on the services of social workers before V–J Day.

It should be pointed out that, along with the expanding use of mili-

tary psychiatric social workers, the American Red Cross was also trying to expand the number of its social work personnel. It had started an active recruiting program, as far back as 1941, to attract more psychiatric social workers. Personnel were recruited through the American Association of Psychiatric Social Workers and from schools of social work. A scholarship program for second-year psychiatric social work students was developed in 1942–43. It was estimated that approximately 300 qualified psychiatric social workers served in the Red Cross Hospital Program during the war—one-third overseas, one-third in administrative and supervisory positions, and one-third specifically in assignments with neuropsychiatric patients in Army general, station, and convalescent hospitals, and mental hygiene units.

SUMMARY AND RECOMMENDATIONS

The writer, who left military service in February 1946, attempted to review and summarize at that time some of the accomplishments of military social work. He wrote:

> Military social work offered an opportunity for civilian social case work to function in a setting of close alignment with, and responsibility to, military psychiatry. From this experience, and based on the pressures of time and volume of need, certain concepts appeared which might be considered unique to military psychiatric social work. As a major contribution, military psychiatric social work was able to demonstrate by on-the-job effectiveness its role as a most important aid to military psychiatry. Many psychiatrists had their first opportunity to work closely with social workers in the Army, and from this experience there developed a new awareness of, and appreciation for, the contributions which social work can make in helping with the emotional problems of soldiers. Conversely, many social workers had their first opportunity to work under the direction of psychiatrists. This opened up new areas of usefulness to them. It gave many of them the incentive to learn more of the interrelationships of the clinical team of psychiatrist, social worker, and psychologist, which proved so effective in the treatment of the emotionally unstable soldiers.

At the time of separation from the service, the following recommendations were made:

> 1) That military psychiatric social work personnel, both in officer and in enlisted status, continue to be used in appropriate military settings; 2) that the proposed plans to establish a training program for psychiatric social work personnel at Brooke General Hospital, San Antonio, Texas, be implemented; 3) that the proposal to include social work personnel in commissioned and in enlisted status in the Tables of Organization for Medical Installations be approved; 4) that liaison be maintained by the Surgeon General's Office through professional representation with the recognized social work organizations in order to utilize their facilities for planning, training, and maintaining acceptable standards of social work practice in medical installations.[18]

[18] It was possible to state, in 1950, when preparing an article for "Adventure in Mental Health" on the Army's Psychiatric Social Work Branch, that each of these recommendations had been implemented.—D. E. O'K.

CHAPTER XXI

The Neuropsychiatric Nurse

Lieutenant Colonel Charlotte R. Rodeman, ANC, USA (Ret.)

GENERAL CONSIDERATIONS

> The history of psychiatric nursing in World War II is brilliant in some specific achievements but totally inadequate as viewed from the total picture. It was brilliant in spots because of the concentrated earnest endeavors of a relatively small number of people who recognized the need for such specialized nursing and overcame great obstacles in attempting to provide it. The total picture was inadequate however, in part because of the cumbersomeness of War Department machinery in quickly establishing necessary facilities and in part because of the apparent failure on the part of all concerned to recognize the need for specially trained nurses in this field if a good job in psychiatry was to be accomplished. A factor of no small importance was the shortage of nurses in the first two years of war.[1]

In World War I, neuropsychiatric personnel including nurses and attendants were assigned directly from the draft,[2] but no such arrangements were made in World War II. In fact, there was great difficulty in retaining trained psychiatric nurses and attendants in neuropsychiatric work.[3] Most nurses were rotated through the different services of a hospital. It appeared that surgical services were usually more successful in keeping trained surgical or operating-room nurses permanently assigned than the neuropsychiatric services.

Between July 1940 and August 1945, 65,371 nurses were commissioned in the ANC (Army Nurse Corps),[4] with a maximum of 57,285 on duty as

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[1] Menninger, William C.: Education and Training in Neuropsychiatry. [Original Manuscript.]

[2] The draft refers only to male attendants and male nurses who were not eligible for appointment in the Army Nurse Corps. The Medical Department made a conscientious effort to recruit nurses qualified in neuropsychiatric nursing and attempted to identify such qualified nurses in the Corps for appropriate assignment. *See* Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, pp. 27–29.—A. L. A.

[3] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 341.

[4] It is of interest to know that the Army Nurse Corps was authorized by statute in 1901, but that its members had neither officer nor enlisted status in its beginning. In a reorganization of 1920, nurses were given the relative rank of officers from second lieutenant to major. In March 1942, the Superintendent and the Assistant Superintendent were commissioned in the AUS (Army of the United States) as colonel and lieutenant colonel, respectively. In December 1942, the relative rank for the corps as a whole was extended through colonel and the pay of grade authorized. It was not until June 1944, however, that Army nurses were commissioned as officers, AUS, for the duration of the war, plus 6 months. The commissions became permanent in 1947. Graduate male nurses, who are most useful on psychiatric services with predominantly male patients, were not commissioned in the Army Nurse Corps until 1955.—R. J. B.

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of V–J Day (2 Sept. 1945).[5] Few States at that time listed psychiatric nursing experience as a prerequisite for licensure as a nurse.[6] A study of over 75,000 nurses who entered the Army and Navy Nurse Corps during the war showed that only 16 percent "had had any undergraduate training in psychiatry in their home school or through affiliation" and only "0.7 percent * * * had had any postgraduate work in psychiatry." [7]

Most nurses "who entered the Army after September 1940 knew little about the administration of Army hospitals." [8] Likewise, the nurses with Army administrative experience, who were assigned as chief nurses, had had little or no experience with hospital neuropsychiatric sections and services that developed so quickly.

Before World War II, there had been little need for trained psychiatric nurses in the Army. Patients who were psychiatrically ill were kept in Army hospitals only until arrangements were made for them to be sent either to St. Elizabeths Hospital in Washington, D.C., or to such other Federal institutions which could provide long-term custodial care or treatment.[9] With the declaration of a national emergency before the outbreak of war, new hospitals were rapidly built on military posts to provide care for the large number of men being drafted into the Army. The typical hospital had closed neuropsychiatric wards designed to give maximum security. The nurses' office was separated from the patient area by a heavy iron grillwork door that was locked when not in use. Open wards were similar to those used for other clinical services. Space and facilities for anything but custodial care were limited in both types of wards. Many chief nurses questioned the need for nurses for patients who were neither physically ill nor confined to bed. The nurse, nominally assigned to psychiatric wards, often actually served much of the time on medical or surgical wards and visited the psychiatric wards to prepare reports and perform other ward administration tasks. In some hospitals, she spent little time in patient areas, especially in the locked-ward section.

This lack of recognition of psychiatric nursing as a clinical nursing specialty resulted in psychiatric patients being under the care of nurses with varying backgrounds; some nurses were well qualified by both education and experience while others had no training and experience in this branch of nursing and also had no desire to work in this field. Well-qualified psychiatric nurses might be assigned to hospitals with no psychiatric wards, while hospitals designated to have neuropsychiatric sections

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[5] Information from Nursing Division, Surgeon General's Office, 1 May 1946. (Personnel Division, Adjutant General's Office, reported 54,128 as total ANC strength.)

[6] Fitzsimons, L. W.: Facts and Trends in Psychiatric Nursing. Am. J. Nursing 44: 732–735, August 1944.

[7] Menninger, "Psychiatry in a Troubled World," *op. cit.*, pp. 118–119.

[8] Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956, p. 32.

[9] This is a common misconception. In actuality, after World War I, psychiatric sections of the medical services existed in all large Army hospitals where definitive treatment was performed. See chapter I, pages 8–9.—A. J. G.

might have few or no nurses qualified to care for psychiatric patients (p. 305).[10]

There had been no special training in the Army for psychiatric nurses before World War II, and no plans for developing such training were in progress at the beginning of this war. Although programs for training were established and carried out in various hospitals during the war, they were hampered by the inability to get War Department approval for an Army-wide school. This situation existed despite the efforts of both the Nursing Division and the Neuropsychiatry Consultants Division of the SGO (Surgeon General's Office). Like most of the developments in psychiatry in World War II, each progressive step was painfully made and only after tedious educational efforts toward those in authority who had no background in this specialty. That the Nursing and Neuropsychiatry Consultants Division regarded the development of psychiatric nurses essential did not appear to be sufficient reason for approving a formal school. Some of the obstacles were in the Surgeon General's Office; many more were at higher echelons.

INSERVICE TRAINING

Unsuccessful Attempts to Establish Formal Courses

Soon after the School of Military Neuropsychiatry was established at Lawson General Hospital, Ga., in December 1942 (p. 43), courses in neuropsychiatric nursing were also planned. A neuropsychiatric nurse was assigned as instructor and the course was outlined. During the next 10 months that the school remained at Lawson General Hospital, the neuropsychiatric nursing course never materialized. The reasons given were the shortage of nurses and the reluctance of hospital commanders to permit nurses to attend the course, as it was believed that they could not be spared from what were considered more pressing nursing activities.

During the latter part of 1943, Col. Florence A. Blanchfield, Superintendent, Army Nurse Corps, prepared extensive plans for courses in psychiatric nursing in several Army hospitals. For reasons unknown, these plans were not concurred with by the Training Division of the Surgeon General's Office.[11] Although the Neuropsychiatry Consultants Division

[10] Shortly before Pearl Harbor, the Superintendent of the Army Nurse Corps requested that the names of nurses qualified in neuropsychiatric nursing be sent to the Surgeon General's Office (see example letter, Maj. Julia O. Flikke, ANC, Superintendent, to Capt. Ida W. Danielson, ANC, Headquarters, Sixth Corps Area, 28 Nov. 1941). Early in 1943, War Department directive (WD Circular No. 34, 1 Feb. 1943) stated that nurses with psychiatric training and experience should be assigned to such work "as far as the exigencies of the service will permit." The Surgeon General notified service command surgeons to maintain a current list of all nurses so qualified (Letter, Maj. Gen. James C. Magee, The Surgeon General, to Commanding General, Headquarters, Seventh Service Command, 20 Mar. 1943, subject: Army Nurse Corps) in an effort to insure their assignment where they were most needed.—A. L. A.

[11] In Technical Manual 12–406, "Officer Classification, Commissioned and Warrant," 30 October 1943, psychiatric nursing was recognized as a specialized field of nursing and coded as MOS (Military Occupational Specialty) 3437. In describing the requirements for awarding this MOS, TM 12–406 stated that nursing experience in a neuropsychiatric ward was essential. It strongly recommended postgraduate training in psychiatric nursing but did not make such training mandatory.—A. L. A.

concurred in the plans, little real effort was made to implement the training of neuropsychiatric nurses, probably because of the untimely death of the director (Col. Roy D. Halloran) and the subsequent change in the directorship of that division.

In October 1943, the School of Military Neuropsychiatry was moved to Mason General Hospital, Brentwood, Long Island, N.Y. Again, plans were made to conduct a postgraduate course for nurses at this hospital. This was finally accomplished in February 1944, but approval to make this an official ASF (Army Service Forces) school was never granted. Nurses assigned to Mason General Hospital were to be given "such didactic instructions as may be feasible with their duty assignment." It was presumed that there would be enough nurses in the hospital so that a limited number would be allowed time off the wards to attend classes; also, the Second Service Command had authorized an overstrength of 10 nurses. However, many hospitals, again, had such heavy workloads that nurses could not be spared to attend the course unless replacements were furnished.

Local Programs

On 5 April 1944, Lt. Col. Ruth I. Taylor, ANC, Headquarters, First Service Command, received information that a course in neuropsychiatric nursing had been started at the Station Hospital, Camp Edwards, Boston, Mass., on 3 April 1944. There are no data available concerning the authorization of the course or why and by whom it was initiated.

On 3 June 1944, in a letter to The Surgeon General, Colonel Taylor stated that the first course in neuropsychiatric nursing would be completed on 30 June 1944 and that 15 nurses would complete the course. Further, that because of the reduced number of patients at Camp Edwards the school would be transferred to Cushing General Hospital, Framingham, Mass., on 1 July 1944. Colonel Taylor recommended that three full-time nursing instructors be assigned to the school at Cushing General Hospital and that the school be approved by The Surgeon General so that an authorized certificate could be presented upon satisfactory completion of the course.

In reply to Colonel Taylor, on 16 June 1944, The Surgeon General concurred with the establishment of a school in the First Service Command at any locality deemed advisable. The Surgeon General, however, did "not deem it advisable to authorize or approve a neuropsychiatric nursing school." While The Surgeon General did not object to the issuance of a certificate of completion, he advised that a local certificate be used since the "Certificate of Proficiency, Various Courses, Special Schools, U.S. Army" (MD Form 60e) was not to be used for local courses.

In December 1943, authority was given to provide a 3-month affiliation in neuropsychiatric nursing at Fitzsimons General Hospital, Denver, Colo., for student nurses from St. Joseph's Hospital School of Nursing in

Denver. In May 1944, Army and cadet[12] nurses were also accepted in the course as students. In June, The Surgeon General authorized official recognition for the course by issuing a certificate to ANC officer graduates.

Service Commands Establish Formal Training

In the fall of 1944, because of continued failure to obtain Army-wide approval for a postgraduate course, all service commands were encouraged to establish their own schools for neuropsychiatric nurse training. By the summer of 1945, each service command had developed such a course for its nurses.

As previously stated, the First Service Command had opened a school at Cushing General Hospital, on 1 July 1944. A total of 10 courses of 3 months' duration was given until the school closed on 8 January 1946. The course included 42 hours in psychiatry, 6 hours in neurology, 6 hours in psychology, and 64 hours in psychiatric nursing lectures, in addition to 5 to 8 hours daily of supervised clinical duty. The school graduated a total of 159 nurses. Capt. Hazel Halladay, ANC, conducted the school under the direction of Col. Jackson Thomas, MC, chief of the neuropsychiatric service. Lts. Helen Durkin, ANC, and Muriel White, ANC, were instructors.

After many difficulties, the Second Service Command began a course at Mason General Hospital, on 14 February 1944. Nine courses of 12 weeks' duration were given parallel to the courses in the School of Military Neuropsychiatry. A total of 153 nurses were graduated. Of the nurses assigned to the school, 21 did not complete the course; of these, 9 were duty personnel, assigned to Mason General Hospital, who, because of the needs of the nursing service, had to withdraw from the course; the remaining 12 were ship's duty and assigned to the school only on temporary basis while their ships were in port. The course included 120 hours of classroom instruction and 456 hours of supervised clinical training. Maj. A. Sue Kerley, ANC, served as director of the school along with her responsibility as the chief of nursing service. The course provided unusually rich clinical experience and profited considerably from its association with the School of Military Neuropsychiatry.

The Third Service Command opened a school on 18 June 1945, at Valley Forge General Hospital, Phoenixville, Pa. The 12-week course was given only once, with 19 ANC officers as students. The program included 135 hours of lecture and demonstration, and the remainder of the time was spent in supervised practice. Lt. Ursula M. Hickey, ANC, was the course director, and Lt. Col. Seymour Rosenberg, MC, was the chief of the neuropsychiatric service.

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[12] These were senior students from civilian schools of nursing who elected and were accepted to serve their final 6 months before graduation in Army hospitals. For a discussion of the Cadet Corps Program authorized by Public Law 74, 78th Congress, *see* The United States Cadet Nurse Corps 1943–1948. PHS Publication No. 38. Washington: U.S. Government Printing Office, 1950.—R. J. B.

In the Fourth Service Command, a school was established at Kennedy General Hospital, Memphis, Tenn., in April 1945. Three courses were conducted, graduating a total of 44 ANC officers. The students in the first class were nurses assigned to Kennedy General Hospital, while the last class had nurses from nine different hospitals in the Fourth Service Command. The course was directed by Capt. Isabelle Mason, ANC, the supervisor of the neuropsychiatric nursing service, under the direction of the chief of the neuropsychiatric service, Lt. Col. Samuel Paster, MC. The course provided 22 hours in psychiatry, 34 hours in psychiatric nursing, 16 hours in neurology, 14 hours in special therapies, 7 hours of training films, 16 hours of demonstrations, and 3 hours in military regulations and varied clinical training.

The Fifth Service Command school at Darnall General Hospital, Danville, Ky., was unable to accept Army nurses from other hospitals because of the lack of housing facilities. However, a 3-month course for senior cadet nurses was established on 1 March 1945, with 71 cadets attending. Capts. Frances Williams, ANC, and Henrietta Rogers, ANC, made up the teaching staff. A total of 36 hours of lectures was given and the remaining time was spent in clinical practice under supervision.

The Sixth Service Command began a 3-month course on 13 August 1945 at Vaughan General Hospital, Hines, Ill. The course here operated under several handicaps caused by the demobilization at the end of hostilities. The director of the course was changed several times (one being separated from the service), and the students were utilized as ward personnel because of the shortage of nurses at the time. A total of 120 hours of lectures and demonstration was given, with the remaining time spent in providing nursing services. Maj. Helen Gray, ANC, was the first director, followed by Captain Larkin, ANC, then by 2d Lieutenant Larson, ANC. Ten nurses completed the course.

In the Seventh Service Command, a course was begun as an affiliation for students from the St. Joseph's Hospital School of Nursing in Denver, on 1 December 1943, at Fitzsimons General Hospital. During the next 2 years, 8 courses were given of 12 weeks' duration, graduating 82 affiliate students and 29 Army nurses. This course continued to be given for students of St. Joseph's Hospital School of Nursing.

The Eighth Service Command established a course at McCloskey General Hospital, Temple, Tex., on 20 October 1944. Five courses of 3 months' duration were given, graduating a total of 71 students. The course provided 32 hours of didactic instruction in psychiatry, 10 hours in military psychiatric administration, 4 hours on liaison with special services, and 62 hours in psychiatric nursing. The course was given under the direction of Lt. Col. Guy C. Randall, MC, chief of the neuropsychiatric service, and Capt. Madeline Weiss, ANC.

Three schools each of 3 months' duration were organized in the Ninth Service Command. Bushnell General Hospital, Brigham City, Utah, estab-

lished a course on 1 April 1945, with 27 nurses attending, and a second course with 24 nurses began on 1 July 1945. Dewitt General Hospital, Auburn, Calif., conducted one course beginning on 17 July 1945, and Dibble General Hospital, Menlo Park, Calif., started its one class on 23 July. These two courses each had 24 students. Each hospital had a full-time nursing instructor, and all the courses had the same general plan, with 207 hours of didactic instruction and varied clinical duty. Students were selected from all the hospitals in the Ninth Service Command and, in most cases, returned to their original station upon completion of the course.

A total of 585 nurses and 296 cadet nurses completed these courses in the hospitals in the nine service commands. Considering the many obstacles which were presented in establishing the service command courses, most of them were well conducted, and able instruction was given in view of the knowledge of psychiatric nursing at the time.

Menninger,[13] in his summary of the aforementioned courses, made the following recommendations:

1. Recognition of an Army Service Forces level should be obtained not only to give the course dignity and standing, but to insure a record of the nurse's completion of training so that she can and will be subsequently assigned as a psychiatric nurse.

2. The students should be accepted as students and not merely used as additional nursing staff to cover the wards. If the course is to be recognized as such, the nurse should be assigned for no other purpose.

3. The selection methods were faulty. In some instances the nurses had no interest in the course, in others they had enrolled as an escape from a previous situation, perhaps with the hope of a change of scenery. In other instances it certainly was not clear to the nurses why they should have been chosen to take the course.

4. The facilities and equipment in most instances were quite inadequate including everything from classroom facilities to the library. The course was forced into being a kind of incidental activity to the psychiatric service.

5. The instructress should have definitely outlined position and relationships. Preferably she should be the Chief Nurse of the Psychiatric Service with an assistant to look after the details of running the nursing service.

This author would add the recommendation that a course should be established and conducted in one installation with qualified teaching and supervising personnel so that all students will be provided with the same types of experiences; also, that students should be chosen with regard not only to personality and intelligence but also to sincerity of interest in this important field of nursing.

Postwar Training Authorized

In 1946, the School of Military Neuropsychiatry was moved from Mason General Hospital to Fort Sam Houston, Tex., and became a part of the Medical Field Service School. The psychiatric nursing course was

[13] See footnote 1, p. 631.

FIGURE 53.—Maj. Charlotte R. Rodeman, ANC, Technical Director of Neuropsychiatric Nursing, Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex., goes over a training chart with Lt. Doris Rasco, ANC.

transferred at the same time and became the only source of training in neuropsychiatric nursing (fig. 53) in the Army; students were drawn from the entire Army Nurse Corps. At first, the course was given partly in conjunction with the course in military neuropsychiatry for medical officers. Army Nurse Corps instructors were assigned and the facilities of Brooke General Hospital were used to provide the students with clinical experience (fig. 54).

This course was 32 weeks long with a capacity of 25 students. The first class started on 17 June 1946 and was graduated in January 1947.[14]

[14] This course continued to be given at Brooke Army Medical Center once or twice each year until 1957. The content of the course was changed, as necessary, to keep in step with current philosophy of psychiatric nursing.—C. R. R.

FIGURE 54.—Maj. Juanita Costa (right) and Capt. Ann Hogan (left) demonstrate the application of a restraining pack used for neuropsychiatric patients to 2d Lt. Zita Ierion and Capt. Jeanine Peterson in the Neuropsychiatric Nursing Course given at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.

OVERSEA THEATERS

Information about psychiatric nursing in oversea theaters [15] was obtained from quarterly and annual reports of hospitals in oversea theaters and from the author's own experiences. Although reports from all hospitals assigned overseas were not available, it can be assumed that the information obtained was representative. This information indicated

[15] The service command programs just described were started so late in the war that they provided few nurses for oversea units before the war ended. Although this volume is primarily concerned with neuropsychiatry in the Zone of Interior, a few examples of psychiatric nursing problems and methods of coping with them are included to underscore the need that existed for an Army-wide program of training and effective utilization.—A. L. A.

that the type of care given to psychiatric patients depended entirely on the attitudes of administrative personnel in charge of the hospital and on the desire and ability of psychiatric personnel to provide good care.

Pacific Ocean Areas

In SWPA (Southwest Pacific Area), several hospitals were designated as neuropsychiatric hospitals. As this related to qualified nurses, Maj. (later Col.) Pauline Kirby, ANC, Assistant Director of Nursing, SWPA, reported, as follows:[16]

> A Psychiatric Nursing Supervisor was placed on duty in the Office of the Chief Surgeon, Hq [Headquarters], USASOS [U.S. Army Services of Supply]. Her first function was to make a survey of nurses in SWPA to determine the number of nurses psychiatrically trained and experienced, who would be available for assignment to—
>
> (1) Hospitals designated to treat minor psychiatric cases,
>
> (2) Closed wards of general hospitals, or specially designated station hospitals carrying psychotic patients.

Thus, an effort was made to assign qualified nurses where patients with psychiatric disorders were hospitalized. Major Kirby reported that the first hospitals specially designated for treatment of minor psychiatric disorders were the 141st Station Hospital, Milne Bay, and the 148th Station Hospital, Oro Bay, both opened for this purpose in January 1944. In February 1944, nurses selected on the basis of personality, intelligence, psychiatric nursing training, and experience were assigned to these installations. The next hospital to care for minor psychiatric cases was the 18th Station Hospital, which accepted patients on 30 March 1944. Specially selected nurse personnel were also assigned here.

During the establishment of these hospitals, it was the duty of the psychiatric nursing supervisor to supervise nursing activities, confer with the nurses, and make suggestions on how to improve the standards of psychiatric nursing care. During hospital visits, she suggested to the commanding officers of the respective hospitals treating minor psychiatric disorders that the nurses—

1. Be given a course in dynamic psychiatry.
2. Be permitted to attend and participate in case conferences.
3. Meet daily with the ward officers to discuss their patients.

The 18th Station Hospital gave 17 lectures on dynamic psychiatry in May and June 1944 and repeated the course in July and August for the benefit of the nurses assigned to the hospital since the initial course was given. Major Kirby included in the ANC history[17] the following outline of a lecture on the role of the nurse in an Army neuropsychiatric hospital which was given in this course:

1. JUST BEING HERE. The "refreshing effect" of having a woman around.

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[16] History of Psychiatric Nursing in SWPA, 1 January–30 June 1944. [Official record.]

[17] *Ibid.*

2. PLAYING THE MOTHER ROLE. The Army has many father substitutes—few mother substitutes. What it means.
3. AS A RECORDKEEPER. Importance of accurate, complete, vivid notes. Future use in evaluating patients' working ability. Usefulness of nurses' notes in getting case-summary. A continued record of patients' day-by-day behavior.
4. AS A SUPERVISOR of certain occupational projects, ward policies, etc.
5. AS AN ADMINISTRATIVE OFFICER.
   (a) Recordkeeping
   (b) Bed check
   (c) Ward management
   (d) Administration of the "Adjustment Index" [18]
6. EDUCATIONAL DUTIES OF THE NURSE.
   (a) As a teacher—
      (1) of junior nurses
      (2) of wardmen
      (3) of patients
   (b) As a student—
      (1) learning from cases and case records
      (2) learning from these lectures
      (3) learning from informal talks with ward officer
      (4) learning from attendance at group therapy assemblies
      (5) learning from watching patients at play and work
      (6) learning from attendance at case-conference
7. THE NURSE AS AN INTERVIEWER.
8. AS A BEDSIDE NURSE for patients requiring medication, diets, etc. Nursing care in narcosynthesis.
9. AS AN OBSERVER—
   (a) of the patient at play
   (b) of the patient at rest
   (c) of the patient at work

It was also suggested by the psychiatric nursing supervisor that nurses attend the arts and crafts classes held for recreational workers by the American Red Cross and that educational programs for nurses be continuous.

Major Kirby further reported that specially selected nurses were also assigned to the 171st and 233d Station Hospitals, both of which operated sections for the care of minor psychiatric disorders. The 116th, 124th, 108th, and 364th Station Hospitals all had sections for the care of psychotic patients, but no mention of the assignment of trained psychiatric nurses to these hospitals was made.

A quarterly report, dated 1 January–31 March 1944, from the 116th Station Hospital indicated that there were psychiatric nurses assigned, as follows: "Two psychiatric nurses from this hospital have served in plane evacuations to the Mainland and have reported little difficulty during the trip."

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[18] The "adjustment index" was the revision of an earlier "psychoneurotic inventory" developed by Lt. Col. (later Col.) S. Alan Challman, MC, Neuropsychiatric Consultant for the Southwest Pacific Area, in October 1943. It comprised a set of 74 questions which required a "yes" or "no" answer and which permitted the discrimination between simple adult maladjustment and psychoneurotic patients. Nurses could monitor the administration of this questionnaire.—R. J. B.

A quarterly report of the 51st General Hospital, in Hollandia, dated 1 October–31 December 1944, indicated a fairly adequate neuropsychiatric staff and some training, as follows:

> The Neuropsychiatric Service * * * a total of 276 beds * * * we have nine well trained Psychiatric Nurses as permanent personnel and six others on temporary duty. * * * The nurses are made aware of their part in the overall picture and are instructed to chart all actions of the patients to be used as an aid in the making of the final diagnosis. * * * Insulin shock therapy is being started and all personnel trained in its use.

A quarterly report, dated 1 April–1 July 1945, of the 60th General Hospital in the Philippines stated that the neuropsychiatric section had a capacity of 68 beds. Since facilities for security wards were not available at this hospital, only cases amenable to open-ward care were accepted for admission. Three nurses on the professional staff were under the direction of a well-trained neuropsychiatric nurse.

It was the writer's own experience in this theater to be the only psychiatric nurse assigned to a station hospital (174th). There was never more than one psychiatric ward in this hospital and acute psychotic patients were usually evacuated as soon as possible because facilities were such that proper care of these patients was not feasible. Much of what was done for patients depended on what could be done with native supplies for occupational therapy, such as coconut shells and wood from packing crates. In Milne Bay, the occupational therapy program consisted of planting quite an extensive garden with seeds obtained from Australia, transplanting flowers from the jungle, building tables and shelves for the ward, and painting peanut and dehydrated coffee cans for use as ashtrays and wastebaskets. The recreational program provided mainly for movies, reading, and games in the Red Cross recreation hut.

For a period of 4 months, the writer was assigned to the 118th General Hospital outside of Sydney, Australia. There were two closed and three open wards here, with an adequately trained staff. Treatment consisted of some insulin therapy, narcotherapy, group therapy, hydrotherapy, and occupational and recreational therapy.

The writer was also assigned to a general hospital in New Guinea for a short period of time. The picture here was vastly different. There were very few trained psychiatric nurses, and little was done for patients. The writer was able to get an occupational and physical reconditioning program started on the ward to which she was assigned but there was little interest or enthusiasm shown among the nursing staff, most of whom tended to avoid patient contact, because of lack of experience with and fear of psychiatric patients. Consequently, most of the actual care of closed-ward patients was provided by the enlisted men assigned, most of whom also had little or no experience in psychiatric nursing. The nurses acted in a supervisory capacity, having patient contact only when giving medications.

That this type of situation existed in other hospitals in this theater is borne out by the following comments from a chief of a psychiatric section of a general hospital in response to a letter of 16 February 1945, from Lt. Col. (later Col.) S. Alan Challman, MC, the Neuropsychiatric Consultant, SWPA:

One phase of the nursing problem can be covered in the following figures. The table of organization calls for 125 nurses and we have available, as of 20 February 1945, 78 nurses of our own. The Nursing Office tells me that they must count on 8 to 10 nurses being out daily because of sickness. Our own Nursing Staff has been augmented by nurses from three separate organizations during our stay here. In short, we must depend on 78 nurses to operate the hospital with assistance when it is available.

There are 58 wards to be operated in addition to the clinics, operating room, nursing administration, etc.

Under these circumstances, the Neuropsychiatric Section runs more smoothly with a minimum of nurses that we can depend on rather than having inexperienced nurses, who are unknown quantities, introduced into the section for varying periods of time which are usually brief. I feel definitely that no nurse should be given responsibility on an NP ward until we know her abilities and she has become familiar with our methods.

Over a period of time, it has been found practical to delegate all possible duties to the enlisted men.

The nurses on the NP Section are not in any real sense psychiatric nurses but act in a supervisory capacity, answer the phone, and take care of the (nursing) ward administration.

This arrangement is far from ideal but again for practical purposes it seems to be the best solution.

* * * * * * *

If you recall a discussion that we had early in our stay at APO 923, regarding the nursing problem you will recognize that the present situation contains no new fundamental issues. Our difficulties on the NP Section have not been unique in this hospital, and there has been general dissatisfaction with nursing policies rather than individual nurses. Possibly, it is the Army ideal that any nurse should be able to do any job at any time that has been at the root of the problem. This morning I asked the Nursing Office if they had any directive regarding psychiatric nursing and they never heard of any such document.[19] In practice we are considered, as we actually are, a part of the Medical Service and the nursing standards are essentially those of medical nursing of which the NP Section has very little.

It has never been possible to get a charge nurse for the whole NP Section and the nursing service has insisted on administering the wards separately and supervision is carried on by the administrative staff who have, as a whole, a minimum of experience in psychiatric nursing.

In short and again from the practical angle, a minimum is expected of the nurses on the NP Section and the main load is carried by the ward officer and the enlisted men. As far as I know, our nursing problem has never been studied by a nurse with any psychiatric background or experience. The present arrangement has the only advantage that it works most smoothly under existing conditions.

It would be of assistance to know of any authoritative Army regulation defining the expected standards of psychiatric nursing care. It would be of assistance if there was a qualified consultant on psychiatric nursing who could advise us.

[19] War Department Circular No. 34, issued on 1 February 1943, urged the "utilization of nurses with psychiatric training."—R. J. B.

It was evident from these comments that the psychiatric nursing situation in this organization was most unsatisfactory and that here indeed psychiatric nursing was not considered a specialized branch of nursing. It seemed to the writer, however, that the author of this letter was himself taking a negative approach, with a defeatist attitude, and might have accomplished more had he made an effort to educate the administrative staff and train the assigned nursing personnel.

European Theater

Reports available from hospitals in the European Theater of Operations, U.S. Army,[20] indicated that the functions of the psychiatric nurses depended largely upon the particular situation and the administrative staff of the hospital and that, in some instances, their main function had little to do with neuropsychiatric nursing activities.

The following points out the effort made to train nurses for psychiatric nursing in one hospital which went to England as a balanced general hospital, in January 1944, and was reorganized as a neuropsychiatric hospital shortly after arrival in England:[21]

> The difficulties encountered in reorganization were tremendously increased by the lack of trained psychiatric nurses. Of the 100 nurses originally in the organization, only one had a Neuropsychiatric Post Graduate Course, and only three had 3 months' affiliation in Neuropsychiatric Nursing while in training. The remainder had little or no previous experience or training. Classes were immediately started in Neuropsychiatric Nursing, and an intensive course was outlined and begun, in which was embodied not only those subjects immediately necessary to the successful operation of the hospital, but the presentation of each lecture was interwoven with an uplifting morale interspersion. The Table of Organization covering that of a balanced general hospital differed from that of a Neuropsychiatric Hospital, as far as the Army Nurse Corps is concerned, in that it required our transferring twenty-six nurses. Today the 96th General Hospital (NP) is staffed with fully capable and efficient Neuropsychiatric Nurses.

That the administrative personnel in this hospital made every effort to train nurses to give efficient care is further indicated by the following section of this 1944 report:

> A plan was evolved whereby the nurses are rotated through each of the three sections, making highly specialized branches of nursing interesting to them, and making them familiar with the function and management peculiar to each section. A great deal of interest was thus created and the shortcomings in experience and training which existed at first have now entirely disappeared. A goodly portion of the nurses are now voicing a preference for a particular phase in Neuropsychiatric Nursing. The Nursing Staff has acquired a maturity of judgment in the handling of neuropsychiatric problems that is more than ordinary, in view of the time the organi-

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[20] For a discussion of a neuropsychiatric training program for Medical Department personnel, including nurses, before the cross-channel invasion of Europe, *see* Medical Department, United States Army. Internal Medicine in World War II. Volume I. Activities of Medical Consultants. Washington: U.S. Government Printing Office, 1961, pp. 366–372.—A. L. A.

[21] Annual Report, 96th General Hospital (NP), for 1944.

zation has been functioning. The administrative problems concomitant with the operation of this type of hospital have been solved in a very satisfactory manner.

Further comment on nursing in this hospital was taken from an interview with Maj. Alexander T. Ross, MC, on 26 July 1945. Major Ross had joined the unit in February 1944 as chief of the neurology service. He stated:

So many of the nurses came over as nurses of an ordinary general hospital. Very few of them had had any psychiatric experience, so it was therefore necessary to institute a course in psychiatric nurse training. This was handled by the psychiatric service and almost all of it was under the supervision of Major [William] Needles [MC]. Training helped them a great deal in understanding the handling of the psychiatric cases. They received much more insight into these cases and a little better understanding of what was wrong with them and how to treat them by this training.

The Annual Report for 1944, of the 36th General Hospital, stated, as follows:

In the neuropsychiatric service the principal consideration has been a physical set up that would assure security to the extremely disturbed patients. Throughout the department, hazards have been eliminated by the engineers and the ingenuity of the ward technicians. The artistic talents of the patients have been employed to decorate the walls of the combined dining room and recreation room with an assortment of cartoons, scenery and household pets.

Neuropsychiatric procedures used have included therapeutic shock by means of a French electro-shock machine, spinal punctures, encephalogram, narcotherapy, narcoanalysis and hydrotherapy. The Wechsler-Bellevue psychometric tests are given by the nurses to many open as well as closed ward patients. The results of these tests aid the doctor in confirming diagnosis. The test not only gives the patient's intelligence quotient, but also the psychological and emotional deviation of the behavior pattern.

It is interesting to note that in this report nurses are only mentioned in the giving of intelligence tests. It would seem that nurses here were primarily occupied with activities that are the concern of psychology. It is reasonable to assume that there were no psychologists assigned here but it is also reasonable to assume that it would be more practical to train one or more enlisted men to administer these tests and permit the nurses to concentrate on nursing activities.

The history of the 30th General Hospital, Belgium, for the period from 1 January to 30 June 1945 indicated that nurses here were also utilized primarily in other than nursing activities:

The nurses in the department did a very fine job in interviewing patients before they were examined by the psychiatrists. Using the NP form designed by Colonel Garrard, they eliminated unimportant information, saving the doctors a good bit of time. Miss Brooks (who replaced Miss Fenney) did most of the intelligence testing in cases where such examinations were necessary. Miss Pardee replaced Miss Isler when the latter went back to the States. Both nurses manifested a fine interest in the work and in psychiatry in general, performing admirably in routine nursing and in some aspects of psychotherapy.

Here again the only activities which were not made specific were "routine nursing," which may or may not mean actual psychiatric nursing.

However, "some aspects of psychotherapy" might have included so-called nursing therapy, an integral part of psychiatric nursing.

Mediterranean Theater

The Annual Report for 1944, of the 51st Station Hospital in the Mediterranean Theater of Operations, U.S. Army, described its experience with neuropsychiatric nursing, as follows: [22]

* * * 1 January 1944, the 51st Station Hospital was located in a medical center at Oran, Algeria. It was at this site that the unit was converted to a Psychiatric Hospital. Although only 15 of the nurses had previous Psychiatric training, the remaining 10 nurses cooperated with the Psychiatric Medical Officers who held special classes in order to orient all the nurses. After caring for surgical patients, it was quite a transition to care for patients who appeared physically sound but were mentally unstable.

The 51st Station Hospital assigned nurses in areas other than traditional nursing, as is indicated in the following:

Five nurses were assigned as Recreational Supervisors in addition to their regular type duties. These nurses work in liaison with the Red Cross Social Service Workers. They were with the patients during organized activities, even participating. This has been a big factor in the therapy program. Once a patient's confidence had been won, the nurses played a very important role by securing information that ofttimes the soldier was not inclined to tell the ward officer. This information often helped the doctor make a diagnosis which otherwise could have been quite difficult.

Even though these nurses were assigned as recreational supervisors, participation in organized activities can be considered a nursing activity, and such activities are part of nursing care in most psychiatric hospitals.

The report from the 262d Station Hospital in the Mediterranean theater, for 1944, showed that its Neuropsychiatric Section had a bed capacity of 60. The only comment on psychiatric nursing was as follows: "The personnel consisted of one Psychiatrist, three nurses, two of whom had previous Psychiatric experience, and the third nurse quickly became very proficient after experience on the Section."

Iceland Base Command

A report dated 6 June 1945 by Lt. Col. Wilfred Bloomberg, MC, Neuropsychiatric Consultant, First Service Command, gave the following report on the 92d Station Hospital, Iceland Base Command.

There are two nurses assigned to the Section, both trained in NP work, and both of them only recently arrived, replacing other trained NP nurses. One of the two now present, Lt. Hagar, the Chief Nurse, had four months at Danvers (Mass.) State Hospital, and since entry into the Army has worked on NP wards, five months at

[22] Training on a theaterwide basis was also reported. For example, U.S. Army nurses and British Army nurses completed a 6-week course in psychiatric nursing at the 114th Station Hospital, North Africa, in the latter part of 1943. See Annual Report, Medical Section, North African Theater of Operations, U.S. Army, for 1943, pp. 279–281, 343.—A. L. A.

Lovell General Hospital, five months at Camp Edwards Hospital, and in addition has had the First Service Command course in Military Neuropsychiatric Nursing. The second nurse, Lt. West, is also NP trained from Providence, R.I. These two officers are thoroughly competent, but suffering somewhat from lack of sufficient work to keep them both busy.

The section at this hospital had one closed and one open ward. At the time of the consultant's visit, there were four closed-ward and seven open-ward patients.

NEUROPSYCHIATRIC NURSING ON HOSPITAL SHIPS

The only information available concerning psychiatric nursing on hospital ships (fig. 55) was an account written by 2d Lt. Helen Sands, ANC, of the 211th Hospital Ship Complement, who was assigned in the Neuropsychiatric Section, U.S. Army Hospital Ship *Emily H. M. Weder* (pp. 339–343).

In her account, Lieutenant Sands stated that there were 10 nurses assigned to the neuropsychiatric section, all volunteers—most with a psy-

FIGURE 55.—The U.S. Army Hospital Ship *Frances Y. Slanger*, named after the first Army nurse to be killed by enemy action in the European theater. New York Port of Embarkation, Brooklyn, N.Y., 1945.

chiatric affiliation as student nurses and many with previous psychiatric experience in the Army. Maj. Matthew Levine, MC, the psychiatrist of the unit, gave lectures on basic theory and principles of normal and abnormal behavior, during the time the unit was activating at Camp Kilmer, N.J. Also, during this time, the nurses worked on the neuropsychiatric section of the hospital "accumulating valuable experience and knowledge of various specialized techniques."

Lieutenant Sands did not give the actual number of beds in the neuropsychiatric section, but stated:

> Each of the wards accommodates eighty patients. The NP section on one deck is divided into two large wards and it is here that our psychoneurotic cases are usually quartered * * *. The deck above contains rooms of four to six beds each, and the cell area which consists of five cells and a latrine. The cell area can be closed off from the remainder of the section if the patients are too disturbed. The variation in the size of the rooms in this section enables us to test the patient's adaptability to small groups, and to segregate them if that procedure becomes necessary.

Lieutenant Sands described one trip from the Philippines to New Guinea, in which the neuropsychiatric section was filled to capacity, as their greatest test. She stated:

> The greatest number of our patients were classified as psychoneurosis * * * [and were] well enough to be permitted use of open decks. Surprisingly few were interested * * * [and] said although they knew the planes flying overhead were ours, they couldn't help feeling afraid * * *. However, they adjusted very well * * *. The psychotic patients were our chief concern * * * about twenty-five of them, most of which were actively disturbed on embarkation. Those five cells * * * were inadequate.

Several of the psychotic patients were "acutely ill physically," and most of them had tropical skin diseases which the restraints had aggravated. While Lieutenant Sands described the psychiatric nursing challenge primarily, she also pointed out that "medical and surgical nursing" skills were "called upon" as well.

Nursing care on the *Emily H. M. Weder* thus consisted of keeping the psychoneurotic patients occupied with recreational activities, of encouraging them to discuss their anxieties and fears, and providing necessary care for any physical illness the patients might also have. Sedative wet sheet packs, sedation, and restraint were used as necessary with psychotic patients. As the need for these decreased, and the physical conditions of these patients improved, emphasis was placed on encouraging them to participate in group activities and to discuss their anxieties.

This account gave an almost ideal picture of an environment conducive to improvement on the part of the patients and of effective utilization of nurses working in a psychiatric team.

NEUROPSYCHIATRIC NURSING IN THE ARMY AIR FORCES

Although little was found concerning the neuropsychiatric activities of nurses assigned in AAF (Army Air Forces) hospitals, they were never-

theless concerned with neuropsychiatric patients. Neuropsychiatric casualties occurred in the Army Air Forces and were channeled through or treated in AAF station, regional, or convalescent hospitals in the Zone of Interior.[23] It may be assumed that efforts were made to assign nurses with psychiatric training and experience, since this was a policy laid down in War Department Circular No. 34, 1 February 1943.

Flight nurses were particularly involved with the air evacuation of neuropsychiatric patients in both the Zone of Interior and overseas. Although the early plans for air evacuation of patients banned the transport of psychiatric patients except in "great emergencies," [24] this policy was changed late in 1944 when neuropsychiatric patients were accumulating rapidly in the Southwest Pacific Area, and hundreds were air evacuated.[25] Many more could have been evacuated but higher authority, aware of the lack of isolation facilities on airplanes, considered neuropsychiatric patients a potential danger. However, air evacuation of all patients, generally, and particularly from ports of debarkation to specialized general hospitals, gained popularity as the war progressed.[26]

The development and training of flight nurses marked a new chapter in nursing history.[27] The first formal graduation of flight nurses of the 349th Air Evacuation Group took place on 18 February 1943. After the first group of 39 were graduated, the school at which they had received training was officially designated as the Army Air Forces School of Air Evacuation, Bowman Field, Ky. A total of 1,079 flight nurses graduated from the course there. In late 1944, the course was moved to the AAF School of Aviation Medicine, Randolph Field, Tex., and 435 additional flight nurses completed the course between November 1944 and June 1946.

In discussing the program at Bowman Field, Link and Coleman made no mention of psychiatric nursing instruction. The course, however, reflected changing concepts in air evacuation of patients, and in describing the course conducted at Randolph Field, they wrote: "Transportation of

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[23] A separate AFNC (Air Force Nurse Corps) was created on 1 July 1949, coincident with the creation of the Air Force Medical Service. As a matter of interest, the following information on the number serving in AAF hospitals is cited from Link, Mae Mills, and Coleman, Hubert A.: Medical Support of the Army Air Forces in World War II. Department of the Air Force. Washington: U.S. Government Printing Office, 1955, p. 61:

Number of Nurses procured from the Surgeon General's Office (Army)	1,625
Number of nurses procured from 1 January 1943 to 1 March 1944 by the Office of the Air Surgeon	3,742
Number of nurses procured by other agencies from 1 January 1943 to 10 May 1944 and assigned to duty with the Army Air Forces	3,557
Total procurement	8,724
Number of nurses transferred to Army Service Forces and Army Ground Forces from 18 December 1942 to 1 January 1945	3,489
Number of nurses on duty in the Zone of Interior as of 1 December 1945	3,461

[24] Link and Coleman, *op. cit.*, p. 384.

[25] Smith, *op. cit.*, p. 444.

[26] *Ibid.*, p. 358.

[27] Link and Coleman, *op. cit.*, pp. 368–378.

neuropsychiatric casualties, always a problem, was thoroughly covered in the program." [28]

CONCLUSION

Although the Army neuropsychiatric nurse was expected to perform those duties relative to the care of neuropsychiatric patients, the military situation and her patients challenged her to do even more. Even though she may have been experienced in State or private hospital psychiatric work, she, like many State hospital trained psychiatrists, found a new type of patient under her care. These patients were not the "psychotics" who constituted the population of most State hospitals but were, rather, frightened, maladjusted, inadequate, defective, homesick, lonely persons frequently labeled as psychoneurotic. Intuitively, and from experience in the nursing arts, these were the first patients to command her attention and to stir her to provide assistance. As she became more experienced in neuropsychiatric nursing, she was able to spread her ministrations more widely.

The Army nurse was probably the most versatile and adaptable officer in the Medical Department and one of the most indispensable in certain medical programs during World War II. These nurses had a way of adapting themselves to a purpose that was unique wherever they served. In neuropsychiatry, they proved their value as members of the neuropsychiatry team. Like many young medical officers who, after exposure to neuropsychiatry in the Army, continued in the specialty in civilian life, so did many nurses. The experience during World War II and the diligent efforts of certain officers in the Medical and Army Nurse Corps pointed out the necessity for continued training and utilization of qualified nurses in the specialized neuropsychiatric area of nursing in both military and civilian practice.

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[28] Link and Coleman, *op. cit.*, pp. 374–376.

CHAPTER XXII

Occupational Therapy in Neuropsychiatry

Major Wilma L. West, AMSC, USAR

EARLY PROBLEMS

This chapter will summarize and evaluate the role of occupational therapy in military neuropsychiatry during World War II, with reference to the need for qualified personnel; the obstacles to program development, how these were met and in what sequence; and the development of programs and the roles of the participants in them.

Need for Qualified Personnel

On 12 August 1943, The Surgeon General, in Circular Letter No. 149, provided for the establishment of occupational therapy departments in Zone of Interior general hospitals. Besides specifically mentioning neuropsychiatric patients as among those for whom occupational therapy was "a valuable adjunct to medical treatment," this directive also stipulated that qualifications for personnel would include graduation from a school of occupational therapy approved by the American Medical Association or registration with the American Occupational Therapy Association. It is of more than passing interest to note that on 3 August 1944, about a year later, with the issuance of War Department Technical Bulletin (TB MED) 80, "Reconditioning Program for Neuropsychiatric Patients," both the original concept of the use of occupational therapy and the qualifications of personnel offering this service were repeated and elaborated in the following manner:

> Occupational therapy enjoys a more important place in the reconditioning program for psychiatric groups than in that of most other patient groups. Therapists who are graduates of accredited schools of occupational therapy and familiar with the problem of emotional and mental disorders are available for supervision. Assistants must be selected from those with arts and crafts or manual arts training.

That the need for qualified occupational therapy personnel was more strongly urged by Army psychiatrists than by physicians in other medical specialties was at least partially attributable to the fact that occupational therapy had its beginnings, earliest recognition, and most extensive use in treatment programs for the mentally ill. Thus, many psychiatrists, commissioned in the Medical Corps directly from positions in civilian hospitals which had used occupational therapy as an integral part of psy-

chiatric treatment, were among the strongest supporters of this discipline's insistence on the use of qualified personnel.

That psychiatry or any other medical specialty would promote this insistence on the use of occupational therapists—at that time in virtually nonexistent supply—versus the employment of nonmedically trained personnel—in far more plentiful numbers and eager to participate in the defense effort—is worth examining. First, there was occupational therapy which, by the military's own estimate, had proved valuable to the Army's Medical Department: "It was the consensus * * * of the officers who came most closely in contact with the occupational therapy work that to it must be credited much of the success of the neuropsychiatric wards." [1] This, however, was written of World War I and few personnel of that time, either in psychiatry or in occupational therapy, could recall this experience and urge its application in World War II. Indeed, it was as if this service and its contribution to patient care had been all but forgotten in the peacetime development of military medicine.

The five occupational therapy training schools established during or immediately after World War I remained the only facilities available and, combined, turned out less than a hundred graduates per year. Most of these personnel, shunning the red tape of the Civil Service, took positions in civilian hospitals. Then, in 1933, nearly all of the few occupational therapists in Army hospitals were discharged from service for reasons of economy. Thus, the Military Establishment made no provision for having a nucleus of qualified practitioners available for service in time of subsequent need.

Volunteer Workers Versus Professional Personnel

Second, and in direct contrast, there were available large numbers of personnel variously qualified but vitally interested in contributing to the war effort. Among these were three types of American Red Cross personnel—paid recreation workers, volunteer Gray Ladies with some craft training, and volunteer members of the Arts and Skills Corps, the latter consisting of outstanding artists and craftsmen, recruited from schools, museums, and various private endeavors, who contributed their time and talent in teaching their specialties to hospitalized servicemen.

Soon after World War II began, the professional and volunteer groups moved in somewhat different directions. Although a few occupational therapists applied for and were assigned to positions in Army hospitals at an early date, their numbers were vastly unequal to the need. Simultaneously, the professional organization was devoting its efforts to assisting The Surgeon General, through the National Research Council, to prepare for a sound and effective service by compiling basic equipment

[1] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, p. 95.

and supply lists; by drawing up space requirements and floor plans for departments; and by specifying requirements for, and assisting in, recruiting qualified personnel and seeking military status for them. In the meantime, and during this delay in meeting personnel requirements, the Red Cross was stepping in to do the jobs on the hospital level. By stretching or converting space for recreational programs and by recruiting additional personnel, the volunteer groups were soon offering arts and crafts for patients in Army hospitals.

Why, then, did The Surgeon General proceed, nearly 2 years after the war had begun, to establish a professional occupational therapy program as "an adjunct to medical treatment"? One can only infer that he and the medical officers and consultants in a position to advise him were convinced of the need for "a particular type of personnel." As Barton[2] wrote, just about this time:

> A correct conception of occupational therapy provides that the doctor writes the prescription for remedial work. He must outline the problem. The occupational therapist then must envision that problem in terms of a wide variety of interesting occupations which will fill the prescription. In neuropsychiatry there is an interest to be developed or emotional barriers to be overcome, outlets for tensions and needs to be found. Occupational therapists must have sufficient medical and psychiatric knowledge to be able to translate the doctor's prescription into work activity based upon the patient's needs, his interests and desires, relieving the busy medical officer of concern about the kind of job.

Early in 1944, a communication[3] to Army medical installations made this concept official and standard for subsequent practice. The pertinent directive of this communication read as follows:

> In order to more adequately serve the purposes of the overall program of treatment and physical reconditioning, it is deemed desirable that all art and handicraft work and related occupational therapy be supervised by the medical staff. To this end, it is directed that such activities as the volunteer Red Cross "Arts and Skills," the Red Cross recreational and diversional arts and crafts program, and any other volunteer activity of a similar nature be arranged and supervised by the department of occupational therapy of the hospital wherever such a department exists.

To the credit of both Red Cross and occupational therapy personnel, this arrangement proved successful in most instances. In those installations where both groups of personnel were employed, it made possible the extension of therapeutic activity programs to greater numbers of patients than could otherwise have been reached by either service alone. In those hospitals for which occupational therapy was not authorized, because of inadequate numbers of personnel—and these included station hospitals in the Zone of Interior and in all types of medical installations in oversea theaters—Red Cross and related groups conducted activity programs of unquestionable value in terms of recreation and diversion.

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[2] Barton, W. E.: The Challenge to Occupational Therapy. Occup. Therapy 22: 262–269, December 1943.

[3] Letter, Deputy Surgeon General, to Commanding Generals, All Service Commands, 26 Jan. 1944, subject: Occupational Therapy Supervision Over Related Activities.

PROBLEMS IN PROGRAM DEVELOPMENT

The three principal problems in program development are listed in the order of difficulty they posed: (1) Personnel, (2) supplies and equipment, and (3) space. Each of these factors is discussed briefly in the paragraphs which follow, as a preface to a subsequent section which details how and in what sequence these obstacles were met and solved.

Obstacles

Personnel

The lack of numbers of occupational therapists adequate to staff Army medical installations was unquestionably the single most serious deterrent to program development. Despite the fact that the war in Europe had begun in the summer of 1939 and that passage of the Selective Training and Service Act, providing authorization for military expansion, had occurred in September 1940, when Pearl Harbor was attacked on 7 December 1941 there were only 12 occupational therapists on duty in 13 Army hospitals. As the war progressed and increasingly larger numbers of U.S. military personnel were sent overseas to both the Pacific and the European theaters, evergrowing numbers of casualties were being returned to the Zone of Interior. To care for these wounded soldiers required the construction of more and more hospitals, thus widening the already serious gap between personnel supply and demand. While other professional groups staffed these military hospitals, primarily either commissioned or drafted enlisted personnel, occupational therapists—99 percent female personnel at this time—were not subject to military service and, therefore, had to be recruited from among volunteers.

Two decisions made by The Surgeon General, early in 1943, proved to be additional deterrents to recruitment. First, it was determined that occupational therapy programs would be established only in Zone of Interior hospitals; second, recognition of military status was denied occupational therapy personnel. A survey of the membership of the American Occupational Therapy Association, conducted soon after these two limitations had been established, revealed that many highly qualified personnel could have been recruited to Army service from civilian positions, if rank and oversea assignments had been offered.

Over and above these specific deterrents, there was an even more serious problem in recruitment; that is, the Army's estimated need for occupational therapists had to be matched against available numbers of professional personnel. In 1941, the Registry of the American Occupational Therapy Association listed 859 occupational therapists in the entire country, which by 1943 had increased to 1,274. With only 43 occupational therapists on duty in 30 Army hospitals, the projected need for 300 was still within reasonable limits of attainment. In early 1944, however, the

opening of many more hospitals, with still others in the process of planning and construction, more than tripled the earlier estimate of needs and made it obvious that the military could not conceivably hope to recruit over 75 percent of the total available supply from civilian ranks. Of further particular relevance was the fact that the great majority of even the limited numbers of qualified personnel, potentially available, were employed in large State psychiatric hospitals. These institutions, already overcrowded and understaffed, were hardly disposed to freeing their personnel for military service. Thus, the establishment of war emergency training courses to train the additional numbers needed seemed inevitable.

Supplies and equipment

The second major obstacle to program development concerned supplies and equipment. The limited peacetime programs of occupational therapy in four permanent Army general hospitals had no standard listing of expendable and nonexpendable material; no table of allowances for hospitals of various sizes; and no adequate compilation of suppliers either for purchasing or to serve as a basis for cost estimates for submission to fiscal authorities. An additional problem in preparing such lists, tables, and supply sources was produced when The Surgeon General's advisers strongly urged replacement of traditional but so-called "feminine" modalities of occupational therapy (weaving, basketry, knitting, and the like) with activities of more masculine appeal. "If occupational therapy is to attract the enthusiastic support of the Medical Department of the Army and of military personnel in Army hospitals, it must adapt its therapeutic occupations to the changing demands of a new war." [4] Thus, such creative and manual arts as woodwork, metal work, and printing—known to the occupational therapist but not among her major skills—had to be emphasized and expanded, and new, unfamiliar activities such as plastics, electricity, and radio repair were suggested as additions. Types, quantities, and sources of equipment and materials essential to all these activities had to be investigated, and specifications for them had to be drawn up for the use of Army purchasing agents. Additionally, there was the necessity for training personnel in their use, which included both the fundamental skills involved in doing the activities and their application to the treatment of the sick and disabled.

Space

Space posed many problems for occupational therapists in the early days of the war but proved the least serious and most easily solved of all major obstacles to program development. Four [5] of the five permanent

[4] See footnote 2, p. 653.

[5] Walter Reed, Fitzsimons, Brooke, and Letterman General Hospitals.—W. L. W.

Army general hospitals had minimal occupational therapy programs and needed only to expand their facilities. As new hospitals were opened and personnel employed to initiate occupational therapy programs, adequate space was provided. The most serious problem in this respect came at about the midpoint of the war when the leasing and conversion of existing facilities and construction of new hospitals was at a peak. At this time, occupational therapy had scarcely been officially established and, thus, no space had been provided in architects' plans.

Solutions

That personnel represented the most difficult of all problems in program development destined it to be among the last solved. Thus, it was that obstacles, presented by lack of supplies, equipment, and physical space, were met and overcome at an earlier date.

Supplies and equipment

The original method of procuring equipment and supplies for occupational therapy was by local purchase through hospital funds. This proved unsatisfactory, primarily because of the time-consuming procedures of the established procurement policy. For each item, a lengthy justification had to be given, complete technical specifications had to be written, and at least three price bids were required from potential suppliers.

First steps in solving these equipment and supply problems were taken early in 1942, when the War Service Committee of the American Occupational Therapy Association worked with a committee of the National Research Council to assist the Medical Departments of both the Army and the Navy in planning occupational therapy programs. Based on estimates submitted by the occupational therapy departments at Walter Reed (Washington, D.C.), Lawson (Atlanta, Ga.), Letterman (San Francisco, Calif.), and Lovell (Ayers, Mass.) General Hospitals, this group compiled a list of basic equipment and supplies necessary to the operation of an adequate occupational therapy program. With only minor modifications to adjust the list to military needs, the recommendations were accepted and became the basis for Medical Department Equipment List 9N464, published on 22 September 1943. The list included 378 items which were authorized as standard issue to all occupational therapy departments in Army general hospitals. To make possible the purchase of selected nonstandard items deemed essential to supplement programs at different installations, annual cash allowances were authorized for local purchases. These allowances were based on the normal rated bed capacity of the hospital and ranged from $1,000 for hospitals of 1,500 beds or less to $2,500 for hospitals of 2,500 beds or more.[6]

[6] Circular Letter No. 149, Office of The Surgeon General, U.S. Army, 12 Aug. 1943.

Although an improvement over hospital fund purchasing, Equipment List 9N464 soon proved inadequate, both in the scope of materials made available and in the amounts authorized. Underestimates in both directions were due as much to program expansion, which could not have been foreseen by original planners, as to lack of precedent in the experience of the advisory group. Then on 20 July 1944, cash allowances for supplemental local purchases were rescinded in order to protect materials which were manufactured for civilian users. With this action, revision of the supply and equipment list became urgent. The revision was submitted in the same month (July 1944) but the new list, ASF (Army Service Forces) Catalog MED 10–23, was not published until 11 January 1945. More seriously, however, procurement was not complete until June 1945, nearly a month after the war in Europe had ended. The revised list included approximately 1,000 items and, with supplemental issue of photographic materials through the Army Signal Corps and authorized local purchases of lumber, proved to be complete and satisfactory.

Space

Physical space, never a problem of the magnitude of either supplies or personnel, was sooner solved, albeit frequently on a makeshift basis in the early days of the war. Open roof areas, solaria, and unused storage buildings were among the facilities often remodeled or transferred in their original form for use by occupational therapy. Even in late 1943, when occupational therapy was officially authorized for all Zone of Interior general hospitals, the space, as stipulated in Circular Letter No. 149, was grossly inadequate: "The space required for an occupational therapy shop will be a minimum of from 750 to 1,600 square feet." As in the case of equipment and supplies, totally adequate provisions were made only after the war in Europe had ended. That came about in June 1945 when space recommended for occupational therapy facilities for the treatment of physically injured patients was between 2,400 and 3,750 square feet and allocations of space for diversional purposes for ambulatory patient groups were based on the bed capacity of the hospital and varied between 4,000 and 5,400 square feet.[7]

Interestingly enough, no official document published during or after the war made specific reference to or authorization for space for neuropsychiatric patients. It is known, however, that on 11 October 1943 recommendations were made by Maj. (later Lt. Col.) Walter E. Barton, MC, Director, Reconditioning Division, to the Hospital Construction Branch, SGO (Surgeon General's Office), concerning therapy facilities at general hospitals (fig. 56). These included provision of small occupational therapy clinics for neuropsychiatric patients only within the neuropsychiatric section. Plans for these and facilities for other special types

[7] Army Service Forces Circular No. 219, 13 June 1945.

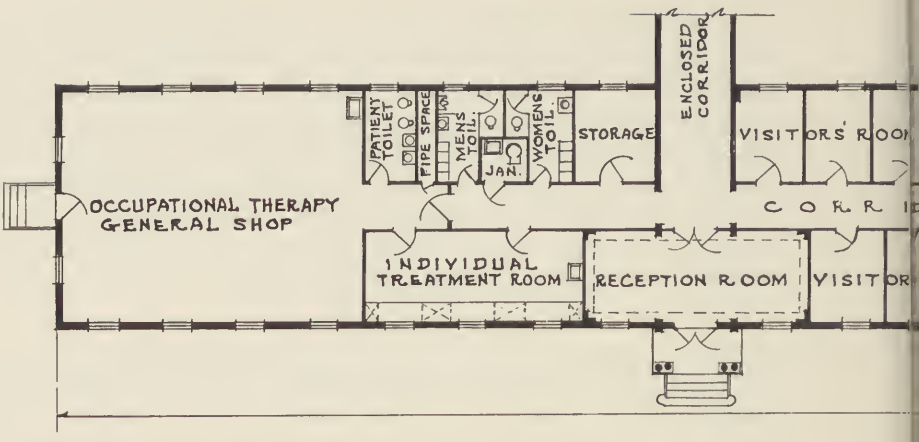


FIGURE 56.—Floor plan, occupational therapy facilities.

of patients were prepared by the Hospital Construction Branch with the approval of the Reconditioning Division.[8] Except in some of the new hospitals to be built, these plans were infrequently used, the majority of hospitals having made their own adaptations or new provisions as required.

Personnel

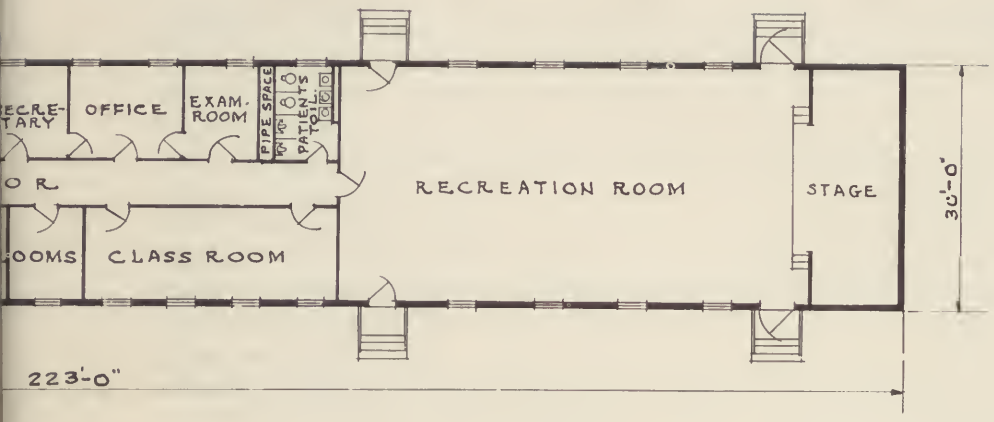
Recruitment.—Concurrently with these efforts toward solution of space and supply problems, the infinitely greater handicap of personnel was being attacked on several fronts. Shortly after the outbreak of hostilities, the War Service Committee of the American Occupational Therapy Association initiated a campaign to recruit personnel by publicizing military service opportunities to all registered occupational therapists. In addition, newspaper, magazine, and radio publicity broadened and reemphasized military needs. Also, schools of occupational therapy were appealed to for help in direct recruitment of their graduates.

On 10 April 1943, Major Barton was assigned to the Neuropsychiatry Consultants Division, SGO, with one of his major duties that of establishing an occupational therapy service for the Army. "The appointment of Colonel Barton for this position was particularly fortunate. His experience in civilian life as assistant superintendent of a large psychiatric hospital included supervision of a large occupational therapy department and instruction of occupational therapy students."[9]

A persuasive speaker, Major Barton addressed both civilian and

[8] Memorandum, Lt. Col. A. L. Tynes, MC, Chief, Hospital Construction Branch, for Maj. Walter E. Barton, MC, Director, Reconditioning Division, SGO, 20 Oct. 1943, subject: Occupational Therapy Installations at General Hospitals.

[9] Willard, Helen S., and Spackman, Clare S. (editors): Principles of Occupational Therapy. Philadelphia: J. B. Lippincott Co., 1947, p. 330.



military groups of various kinds on the need for more and better occupational therapy in Army hospitals. His prolific writings, published in *Occupational Therapy and Rehabilitation,* the *American Journal of Psychiatry,* and *Diseases of the Nervous System,* seldom failed to promote the value of dynamic activity programs in treatment of the neuropsychiatric patient. He also authored the early official documents establishing occupational therapy in the Army Medical Service and, finally, secured the appointment of an occupational therapist to the Office of The Surgeon General for the purpose of carrying on the work he had so well begun.

His successor in this effort was Mrs. Winifred C. Kahmann, Occupational Therapist, who, on 18 November 1943, became Chief of the Occupational Therapy Branch, Reconditioning Division, SGO. On this date, there were only 43 occupational therapists on duty in 30 Army hospitals in this country. With the immediate requirement estimated at 300 and the military medical program still expanding, recruitment was the single most important need. Thus, prime among Mrs. Kahmann's earliest efforts were talks at occupational therapy schools and State association meetings and correspondence and interviews with individual therapists to interpret the urgent need for qualified personnel in the Army program. In less than 2 months, she had more than doubled the number that had been on duty at the time of her appointment[10] and in another 6 months had doubled it again[11] and increased to 52 the number of general hospitals to which these personnel were assigned.

Training.—In the meantime, however, it had become evident that even this rate of expansion could not meet the need, for no hospital had

[10] The Surgeon General's Notebook, Report of the Reconditioning Division for 1–15 Jan. 1944, par. 3a: "Thirty named general hospitals now have ninety occupational therapists on duty."

[11] Annual Report, Reconditioning Division, Office of The Surgeon General, U.S. Army, 1943–44, Occupational Therapy Section, p. 8: "1 June—one hundred and eighty (180) occupational therapists are now on duty in fifty-two general hospitals."

its authorized strength of 1 therapist to 250 patients, and the number of therapists on duty was only 24 percent of that authorized. Thus, in March 1944, a request for the establishment of an emergency training course was forwarded to the Commanding General, Army Service Forces. In late June, this was approved,[12] and during July, the first 111 students were enrolled in the new program which was initiated at five civilian schools[13] under Government subsidy. It was a near heroic achievement which made this course a reality in so short a time since legal contracts had to be drawn up and arranged with the participating schools, publicity released on course availability, civil service appointments effected, and travel orders written. Many enrollees, it was subsequently revealed, had little or no notice between acceptance and assignment to school, and several confessed that the only reason they did report on schedule was that their interpretation of the travel "orders" was a completely literal one.

War Emergency Course.—The War Emergency Course outline was prepared in conjunction with the War Manpower Commission and the Committee on Education of the American Occupational Therapy Association. It consisted of 4 months' intensive study in basic sciences, medical subjects, and theory of applications of occupational therapy, followed by 8 months of clinical practice in Army hospitals selected as having registered occupational therapists qualified to direct this applicatory portion of the total education program. Candidates admitted to the course were selected from among applicants presenting a bachelor's degree with a major in fine or applied art or home economics with a knowledge of not less than three manual skills and of basic psychology. Those accepting training in this Government-subsidized course were expected to serve with the Army for the duration of the emergency and 6 months thereafter, if needed.

Planned to qualify a total of 600 graduates, these courses were conducted at 2- and 4-month intervals until 1 July 1945, when the last 170 students to complete didactic training entered hospital apprenticeships. Three more schools[14] joined the original five in giving 21 courses which ultimately enrolled 667 students. Of this number, 605 completed the academic portion and 545 finished clinical training, 122 (18 percent) having resigned or been separated for academic failure, inability to adjust to hospital service, illness, marriage, or other reasons.

One month after the establishment of the War Emergency Course, eligibility for the 8-month clinical portion of it was extended to include students in accredited schools who had already completed the theoretical part of their education.[15] This subsidy of nearly half of the required

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[12] Army Service Forces Circular No. 189, 22 June 1944.

[13] Milwaukee-Downer College (26), the Universities of Illinois (23) and Southern California (24), and the Philadelphia (23) and Boston (15) Schools of Occupational Therapy.

[14] Columbia University, Mills College, and Richmond Professional Institute of the College of William and Mary.

[15] Army Service Forces Circular No. 263, 15 Aug. 1944.

training enabled the recruitment of an additional 150 civilian students who were thus placed on duty in Army hospitals nearly a year before they would otherwise have become available, assuming that they would then have volunteered for military service.

Wacs.—Had these procurement methods been initiated at an earlier date, the needs for personnel would have been met sooner and more adequately. However, with the prospect of nearly a year's time elapsing before even the first enrollees in either program could be fully qualified, it was evident that still further means had to be found to alleviate the acute personnel shortage. Therefore, on 4 November 1944, The Surgeon General recommended establishment of a course for training WAC (Women's Army Corps) personnel as assistants to occupational therapists; in less than 2 weeks, this recommendation was approved.[16]

Prerequisites for this course included high school education, knowledge of or ability in handicrafts, and aptitude for teaching. Candidates were secured through a general WAC recruiting campaign for medical technicians and were assigned for basic training at either Fort Oglethorpe, Ga., or Fort Des Moines, Iowa. The program of instruction for the 1-month course included 192 hours of lectures, conferences, demonstrations, and instruction in the principles and aims of occupational therapy, plus practical application of various crafts and manual skills. Training was conducted at Halloran General Hospital, Staten Island, N.Y., by a WAC officer, a registered occupational therapist, under direction of the Surgeon General's Office. On completion, trainees were returned to their service commands for assignment to hospitals having established occupational therapy departments. The 11 courses, completed between 9 December 1944 and 27 October 1945, graduated 278 occupational therapy WAC assistants who, by assuming responsibility for diversional programs in many Army hospitals, freed the occupational therapist for treatment of psychiatric, neurological, and orthopedic patients.

As events were later to prove, even these three emergency training programs failed to meet personnel requirements for occupational therapists in Army hospitals. Although the end of the war with Japan saw occupational therapy established in all 76 general and convalescent hospitals then in operation, with personnel totaling 899, "it is to be noted that of this number only 447 were graduates and 452 were apprentices still in clinical training." [17]

Other facts might also be noted about these preceding statistics. First, few if any of the general and convalescent hospitals had their authorized strengths at this time, nor did they reach them until several months after the war when deactivation of many temporary installations made possible more adequate staffing of remaining hospitals. Second, the

[16] Memorandum, Brig. Gen. R. W. Bliss, The Surgeon General, for Commanding General, ASF, 4 Nov. 1944, subject: Orientation Training for OT Assistants (WAC), with 1st endorsement thereto, 16 Nov. 1944.

[17] West, W. L.: The Future of Occupational Therapy in the Army. Am. J. Occup. Therapy 1: 91, April 1947.

earliest date on which occupational therapists were assigned to convalescent hospitals was March 1945;[18] regional and station hospitals were not authorized occupational therapy personnel until October 1945[19] and February 1946,[20] respectively. Thus, of the 899 therapists on duty at the end of the war, with 545 being emergency-course personnel and 150 Army-trained clinical affiliates, the total number of previously qualified therapists entering military service barely exceeded 200.

DEVELOPMENT OF SPECIFIC PROGRAMS

Occupational therapy departments in World War II Army hospitals developed four specific programs for the four major classifications of hospitals; that is, general, convalescent, regional-station, and specialty. A description of the major occupational therapy programs in each situation follows.[21]

General Hospitals

Two types of programs, the closed ward and the open ward, were found in most of the Army hospitals which were designated as having specialty treatment services for psychiatric patients. These were necessitated by the degree of illness of the patients which, in turn, dictated their assignment to either closed or open wards.

Closed-ward program

A review of the annual reports of 16 of the 29 hospitals caring for psychiatric patients indicated that nearly all of them had some type of closed-ward program for these patients. Often, this was given priority in terms of personnel assigned and separate facilities provided, although there were occasional instances noted of referring to occupational therapy those open-ward psychiatric patients who were able to report to a general clinic area serving all types of patients. In most of these hospital reports, however, reference was made to separate occupational therapy facilities within or immediately adjacent to the neuropsychiatric wards. Where no specific building or ward area could be allocated for this purpose, therapists operating out of a central clinic transported materials and supplies into

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[18] Semi-Monthly Report of the Reconditioning Consultants Division for the Period 1–15 March 1945, 16 Mar. 1945.

[19] Army Service Forces Circular No. 380, 9 Oct. 1945.

[20] Army Service Forces Circular No. 38, 14 Feb. 1946.

[21] Material for this section was gathered from various sources, such as hospital annual reports for 1944–45; published and unpublished papers on occupational therapy written during the war years; statistical, case history, and other data collected from numbers of Army hospital occupational therapy departments immediately following the war (by the Office of The Surgeon General and for purposes such as this history); and, to a lesser degree, from personal communications and conversations with Army therapists and psychiatrists.—W. L. W.

the closed wards and conducted both individual and group activities in daily 1- or 2-hour treatment periods.

The most frequently occurring diagnoses among closed-ward patients were schizophrenia, manic depressive psychosis, occasional paranoid states, and some acute psychoneuroses. Found in smaller numbers were psychopathic personalities, mental defectives, psychosomatic disorders, hysterical paralyses, and others.

The literature of the ward period is probably representative of the objectives of therapeutic activity programs in Army hospitals during that time and indicates that the function of occupational therapy was perceived as generally supportive rather than dynamically oriented in dealing with psychopathology, as follows:

1. To prevent mental and physical deterioration.
2. To encourage socialization and a feeling of group identification.
3. To stimulate creative imagination and expression.
4. To reduce poverty of ideation.
5. To provide self-confidence and a sense of security.

For most closed-ward patients, occupational therapy was individually prescribed by the medical officers. Since psychiatry at this time was still more descriptive than dynamic, these prescriptions usually stated little more than a diagnosis of major symptomatology and, if indicated, precautions related to suicide or homicide. Potential but as yet unformed elements of the prescription were interpersonal relationships with the patient, the dynamics of group interaction, and the multidisciplinary approach (in conjunction with psychologists, social workers, and recreational personnel). For the most part, therefore, the therapist was given only a name and a clinical label or impression on the referral form.

In accordance with doctrine stated in the then current manuals on occupational therapy [22] and psychiatry,[23] some of the treatment principles used were as follows:

1. For schizophrenic patients:
   a. Group activities to stimulate identification and interaction (for example, publishing a hospital newspaper).
   b. Creative art for nonverbal expression (for example, painting and music).
   c. "Dirty" activities for the untidy and the "smearers" (for example, clay modeling and finger painting).
2. For manic patients:
   a. Activities requiring gross physical motions (carpentry).
   b. Work situations permitting freedom of movement without close contact (gardening).
3. For depressed patients:

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[22] War Department TM (Technical Manual) 8–291, "Occupational Therapy," December 1944, ch. 5.

[23] Solomon, Harry C., and Yakovlev, Paul I. (editors): Manual of Military Neuropsychiatry. Philadelphia: W. B. Saunders Co., 1944, pp. 606–607.

a. Simple, readily achieved, time-limited tasks (based on previous hobby interests).

b. Menial (janitorial) work for guilt atonement.

c. Selection of types, locations, and tools of work with awareness of suicide precautions.

4. For paranoid patients:

a. Individual work assignments involving responsibility (clerical).

b. Jobs permitting a high standard of performance (selected in accordance with individual interests and abilities).

5. For psychoneuroses—activities selected to counteract symptoms:

a. Physically demanding for the tense and restless.

b. Requiring skill and concentration for the introverted and anxious.

c. Doing something for others (family or hospitals) for the discouraged and depressed.

6. For psychopaths—strictly supervised and sternly disciplined activities (for example, industrial assignments).

7. For mental defectives—short-term tasks within their abilities to accomplish (with constant supervision, protection from ridicule, tolerance of error, and liberal praise for achievement).

8. For psychosomatic disorders—absorbing, detailed tasks to overcome concern with complaints and motivate patient toward normal interests and recovery (fig. 57).

9. For neurological problems—activities incorporating principles of physical treatment with maximum psychological motivation.

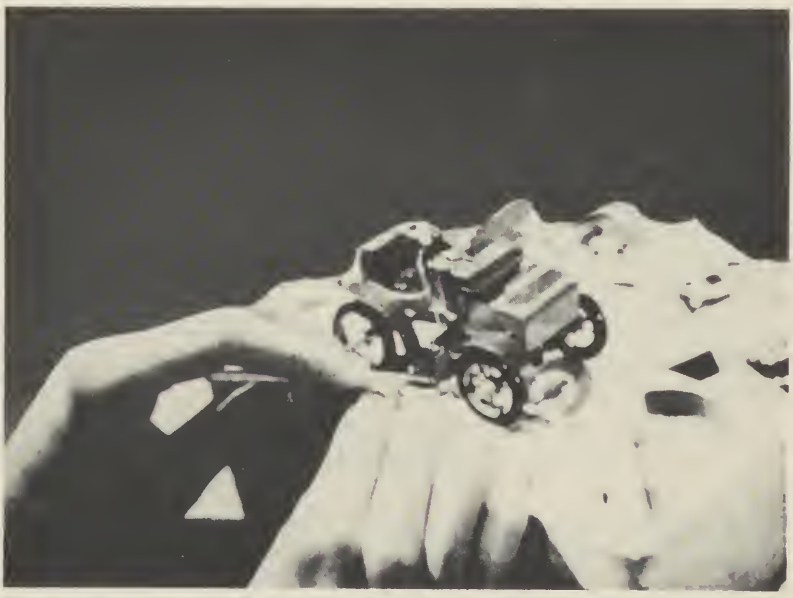

FIGURE 57.—Miniature model building in occupational therapy.

A somewhat limited range of activities (the traditional arts and crafts, music, drama, puppetry and recreation) was used in occupational therapy programs for closed-ward patients because of precautions which, it was believed, had to be observed and because facilities off the ward were not always available. However, in situations where completely equipped work areas were provided and adequate numbers of personnel were available, a proportionately broader selection of creative and manual skills was provided.

Fairly close supervision of the work of closed-ward patients was considered mandatory in most programs for the purpose of providing support and external control of the acutely disturbed. Frequently, this required the assignment of enlisted corpsmen to duty in occupational therapy during periods when patients were engaged in activities. Shop doors were, of course, locked, and tools were carefully checked at the end of each period, before patients were returned to their wards.

Many if not all occupational therapists working with locked-ward patients wrote weekly progress notes for the information of the referring psychiatrist and for incorporation into the patient's medical record.

Another occasionally used but by no means standard method of correlating overall treatment programs was the staff conference. Attended by clinical psychologists, social workers, and occupational therapists, these meetings relayed to the psychiatrist observations by various team members on the behavior, attitude, and reactions of patients, thus providing the basis for such changes in the prescribed treatment program as might be indicated.

Open-ward programs

Since there were more open-ward patients than closed-ward patients, greater numbers of the open-ward patients were referred to occupational therapy, the ratio being 3 to 1 in some instances. Of the 14 hospitals reporting on the numbers of psychiatric patients in occupational therapy during 1945, the figures ranged from 45 per month at one hospital where occupational therapy was selective in terms of patient need ("puppets for a group psychotherapy demonstration on dependency" were used)[24] to 550 patients per month at another facility where "attendance in the Neuropsychiatric Occupational Therapy Shop is compulsory for all open-ward patients."[25] Between these extremes, hospitals reported wide variations in census of these groups, with the average being 234 patients per month.

The four basic types of military neuroses and the doctrine observed in occupational therapy for these patients were generally, as follows:[26]

1. Neuroses occurring before exposure to military life could have any

[24] Annual Report, Schick General Hospital, Clinton, Iowa, 1945, p. 126.

[25] Annual Report, Bushnell General Hospital, Brigham City, Utah, 12 Jan. 1946, p. 7.

[26] Stakel, F.: Occupational Therapy for Neuropsychiatric Patients in an Army General Hospital. Occup. Therapy 23: 225–229, October 1944.

manifestation. In this group were patients whose difficulties dated back to childhood but were exaggerated by military service. Many of these patients were classed as psychopathic personalities. Often antisocial and with destructive tendencies, such patients were frequently disciplinary problems on the wards. Their prognosis was poor, and most of them were ultimately discharged from the service.

The therapist usually tried to incorporate these patients into the industrial therapy program. Because they were behavior problems, it was believed that any constructive activity, especially projects for the hospital, was highly advisable.

2. Neuroses caused by the restrictions of military life. The prognosis of these patients was good if an adjustment could be made, and frequently, they were returned to duty. Rarely were disciplinary problems found in this group. Their symptoms were usually tenseness, loss of appetite, inability to sleep, and depression over their failure in the service.

Often the therapist would plan a program involving fairly strenuous physical activity, such as a woodworking project, to provide a physical drainage of energy to lessen tension and anxiety. A good workout in the shop usually helped to regain appetite and often induced sleep.

3. Neuroses caused by foreign service with its homesickness and poor living conditions. These patients had poor prognoses and were usually discharged from the service. Their backgrounds frequently included neurotic behavior, and symptoms were exaggerated as soon as they were sent overseas. They were rather similar to the first group and needed socialization and constructive activity but were not necessarily antisocial. If they had psychopathic personalities, they were of the mild type.

These patients were generally worked into the industrial therapy program. Although a cooperative group, results with them were not outstanding.

4. War neuroses caused by actual combat. These cases had a good recovery prognosis but were not always returned to duty. They were largely men who had always adjusted well in civilian life and in the Army until placed under the severe strain of combat. Often they were depressed, restless, tense, sensitive to noises, and unable to sleep because of battle dreams. They were a difficult group to reach at first because of depression and restlessness, and in addition, they often had tremors of the hands when attempting to work.

With these patients, occupational therapy frequently had good results. Short projects with a high interest level such as leather work were attractive to them. Once their interest had been aroused, they were cooperative, appreciative, and showed marked improvement in a few days. If these patients showed any inclination to discuss their experiences, they were urged to do so. Some depicted combat experiences or battle dreams in various art forms and, where the patient was thus able to express himself, therapy was decidedly beneficial.

There were three major differences between open- and closed-ward occupational therapy programs. First was the incorporation of many open-ward patients into shops serving patients with physical disabilities. In some instances, such combined groups resulted from lack of separate facilities but, in others, the practice was followed on the theory that neuropsychiatric patients, particularly those who were not so sick, might well benefit from contacts with more "normal" groups.

A second contrast in programing was found in the wider variety of activities available to open-ward patients. Thus, in addition to the traditional arts and crafts, shops used by open-ward patients included facilities for photography and letterpress printing, areas for gardening, and power tools for extensive woodwork, plastics, and metalcraft. This is not to say that such activities were never used in closed-ward programs, but, as a general rule, the open-ward patient had a far greater range of choice.

One other type of activity—industrial therapy—was extensively used in treatment of the open-ward patient whereas it was rarely applied in locked-ward sections of the hospital. Passing reference has been made to "industrial assignments" in discussing treatment principles for both types of patients. However, since the theory as well as the method bears further elaboration and since this feature characterized some of the most successful open-ward programs, a detailed discussion follows.

Industrial therapy

At the outset, a distinction must be made between two quite different programs, both of which were occasionally referred to as industrial therapy. The type most frequently used in treatment of the neuropsychiatric patient who had progressed beyond the need for definitive therapy involved assignment to various departments and services concerned with maintenance and operation of the hospital. Often confused with industrial therapy, because of the application of similar terms such as "Work Therapy," "Job Therapy," and "Commercial Therapy," were various experimental projects which involved the employment of hospital patients on subcontract work projects for war industries. These programs, often mistaken for the type of industrial therapy discussed here, were more extensively used with the physically handicapped than with the neuropsychiatric patients. The later development of these explorations in "factory-in-hospital" programs, prevocational training, and preparation for reemployment of the handicapped within civilian industry is worthy of mention. Programs of this type in selected Veterans' Administration and civil hospitals developed largely out of the pioneering and experimental programs conducted by the military service.

More commonly used in occupational therapy programs for open-ward psychiatric patients was the industrial therapy officially defined, in TM 8–291, as "the use of an industrial assignment or work project for its

therapeutic effect." The concept of this program was hardly a new one, having been traditional in State hospitals from the earliest recorded use of activity as treatment. As applied in Army hospitals, some of its aims were—

1. To reduce actual psychosomatic symptoms.
2. To return a feeling of self-sufficiency and ego strength, decreasing the patient's depression and feelings of inadequacy through graded normal work situations.
3. To employ mentally defective persons during the period of hospitalization, so that they might feel useful members of society, and to provide a means of vocational exploration.
4. To provide an opportunity to regain work habits or to brush up on a specific work experience in order to return a feeling of security in the work sphere.
5. To give the patient a situation in which he could improve his social skills by dealing with increasing numbers of people, as well as with authority, in a semisheltered and tolerant atmosphere.

Administration of the industrial therapy program included the following:

1. A job analysis, with reference to mental and personal requirements, physical demands, and environmental and industrial or other hazards.
2. The prescription, containing identifying data about the patient, his diagnosis, physical condition, mental characteristics, precautions, and purpose of prescribing occupational therapy; that is, for prevocational exploration, socialization, sedation, stimulation, or other aim.
3. Records, including summary data from the referral, supervisor's ratings and any change, with reasons therefor, made in assignment.
4. Progress reports, the rating of patients with reference to regularity of attendance, ability to follow instructions, degree of cooperation, and attitude toward assignment.

Job openings filed with the Industrial Therapy Program at Newton D. Baker General Hospital, Martinsburg, W.Va., represented a broad range of work assignments in the professional, maintenance, supply, and entertainment services of the installation.

Convalescent Hospitals

Occupational therapy programs in convalescent hospitals were markedly different from those in general hospitals. This contrast was primarily due to differences in the degree of illness of patients and in the type of facility represented by the convalescent hospital. Designed to remove neurotic patients from the more seriously ill and the formal atmosphere of hospital beds and white uniforms, these facilities were patterned after Army field units with the patients organized into battalions, dressed in duty uniforms, and generally taking care of themselves.

Often, well over 50 percent of the patients in these hospitals were "psychoneurotics." Experience, primarily in combat zones, had shown that, although these patients did not require either closed-ward care or intensive individual therapy, they benefited by a comprehensive program designed to prevent the development of apathy, resentment, overconcern with somatic ailments, and fixation of symptoms. Thus, although the treatment and training were under complete medical supervision, the Army convalescent hospital featured an elaborate program of physical reconditioning, educational classes and shops, recreation, occupational therapy, and counseling.

Not all patients in this setting were referred to occupational therapy since a number of them arrived at the hospital willing and able to participate in physical reconditioning and educational classes. After vocational classification and counseling by the medical officer and social worker, such patients were assigned directly to other activities.

For others, however, occupational therapy was a prescribed treatment and considered to be the link between the treatment services of the psychiatric staff and the services of the reconditioning program. As such, occupational therapy was primarily concerned with that borderline group of patients who were too antagonistic toward or emotionally unable to cope with the more formally organized classes and activities.

In the convalescent hospital, therefore, occupational therapy was designed to meet the needs of patients whose condition demanded a partially controlled environment with supervision by medically oriented personnel. Those patients presented typical psychoneurotic symptomatology, distortion of social perspective, hostile attitudes, feelings of inadequacy, confusion, and occasional residuals of a more serious emotional disturbance. A prime aim of all services concerned with these patients was reinforcement of their ego strengths in interpersonal and group relationships.

Again, because the precautions were minimal and the activity potential was greater in these than in general hospital patients, a wider variety of modalities was offered. Dividing the sections of the total occupational therapy area into machine shop, quiet shop, art studio, and the like, patients were permitted to move freely between activities with a minimum of direction from supervisory personnel. In contrast with techniques employed for the psychotic, it was found that convalescent hospital patients responded better to more freedom in choice and process of activity. Daily attendance in this casual kind of environment tended to reduce hostile attitudes and to foster the self-confidence and security so needed by these patients.

Prescriptions from referring psychiatrists usually requested observation and a report on social relationships and behavior, on work tolerance, and on educational or vocational aptitudes. The findings of the occupational therapist were used in screening patients who had made sufficient progress in the treatment situation to warrant reassignment to the edu-

cational program. For some patients, the successful completion of one activity in occupational therapy provided the self-assurance needed to attempt something more advanced. Others required a longer period of adjustment in this more sheltered setting but, ultimately, found that they wanted to progress to a more advanced and technical level. When such attitudes and abilities were first observed in a patient, the occupational therapist might recommend reevaluation by medical and consulting personnel and thus help expedite the patient's transfer to an educational class or pretechnical shop.

With the end of the war in the summer of 1945, the average stay of patients in convalescent hospitals as well as in all other Army medical facilities was greatly shortened. At this stage of program development, the practice of using occupational therapy to screen patients for educational reconditioning (in those installations where this function was predominant) became impractical and it was thereafter used as an alternate rather than as a preliminary assignment. Medical referrals continued to single out the more severely ill patients and also those who, although not so sick, requested occupational therapy in order to achieve improvement in a shorter period of time.

The cross section of patients seen in these hospitals invariably included those who needed a variety of short-term projects with tangible results. For these patients, and for those needing to rebuild powers of concentration, to resolve problems in interpersonal relationships, to test performance ability, to seek attainable levels of achievement, occupational therapy afforded a wide range of interest-motivating activities.

Regional and Station Hospitals

As has been previously noted, personnel shortages precluded assignment of occupational therapists to regional and station hospitals during the war period. Thus, to all intents and purposes, there were no officially recognized or professionally staffed occupational therapy departments in these installations during the time period with which this history is concerned. Yet reports from station and regional hospitals contain accounts of programs termed "occupational therapy," which in some instances are so obviously worthy of the name as to warrant discussion and inclusion in this section.

Zone of Interior

One of these "occupational therapy" programs was initiated early in 1943, in conjunction with reconditioning, at the Harmony Church Annex of the Fort Benning Regional Hospital, Ga. The following highlights the "occupational therapy" portion of the reconditioning program recorded in "History of Reconditioning of Military Personnel Returning to Duty":

The plan of the whole program was to relieve the psychological malady of "hospitalitis" and to prepare the men physically and mentally for return to their own units in the quickest possible time.

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In addition to regular calisthenic periods, physical exercise in the nature of occupational therapy was encouraged by the special atmosphere surrounding this Hospital Annex. Among the projects constructed and worked on by trainees were a chicken house and a garden which contributed not only to the health of the men participating in the construction and working of these activities, but to the menus at the Annex mess hall. In addition, a carpenter shop was operated by the trainees and equipment for the operation of the Annex, as well as visual aids to be used in the instructional program, were made in this shop by the trainees.

Under the guidance of a Sanitary Corps officer, trainees who were interested in masonry and bricklaying constructed a full-size out-door model sanitary area, consisting of twelve units including an underground trench incinerator, human waste vaults, garbage disposal plants, improvised outdoor showers, an underground food storage vault and other units. This area contributed, by way of occupational therapy, and was later used as a demonstration area for lectures in field sanitation and sanitary appliances. Other projects which contributed to the occupational therapy programs, and likewise to the facilities of the Hospital Annex, were a barbecue pit, a fish pond, an archery range, fences, a rustic park constructed from native pines and various areas for the use of game equipment.

Another account[27] of interest and ingenuity of the supervising psychiatrist described a do-it-yourself occupational therapy program organized at a station hospital during the war years. In this instance, lack of support from command prompted the chief psychiatrist to solicit $5 donations from his staff to place in a "kitty" in order to purchase supplies and tools to implement the salvage material which was being used. After the initial supplies were purchased, they were sold to the patients at cost, thus maintaining the "kitty" for continuous purchases. This little nest egg was periodically swelled by donations from local religious, fraternal, and other organizations. These donations permitted the furnishing of materials to patients without charge.

Supplies, however, were still scarce and when no funds for purchases were offered, "scrounging" for material often became necessary. The salvage dump was frequently visited. Paint, varnish, shellac, and sandpaper were obtained from the paintshop. One project, done very quietly, was the sanding, refinishing, and varnishing of every bedside table in the hospital. The bedside tables, of the oak-folding type, were refinished to look like new. Then, one of the patients who had been a commercial sign painter in civilian life was motivated by his physician to redo a number of makeshift hospital signs in a standard size, format, and lettering style. Gradually, as more and more of the new signs began to appear around the hospital, the commanding officer tracked down the source of this professional appearing work and, impressed by a form of occupational therapy which did not consist of basket weaving and crocheting, asked the insti-

[27] Personal interview with Lt. Col. Robert J. Bernucci, MC, Neuropsychiatric Service, Camp Livingston, La., 1942–45.—W. L. W.

gating psychiatrist how much was needed in monthly funds to expand the program. Having indicated that $100 a month would probably be adequate, the psychiatric staff was overwhelmed to receive, within 2 days, authorization to draw $300 monthly from the hospital fund.[28] Although both patients (given "kitty" money and authority to purchase materials while on furlough) and staff (using local resources) shopped with abandon, the maximum they could spend in any one month was $150. Additional materials were requisitioned from the hospital table of allowances, for some of which ingenious justification was required.

Therapeutic activities at this hospital, however, included more than handicrafts. The patients, no less ingenious than their medical officer, made a simple jigsaw almost entirely of wood, its only metal parts being the saw blade, two small bolts, and a single bedspring salvaged from a damaged hospital cot. Numerous similar activities at this and other hospitals were conceived and, by various means, implemented as treatment for neuropsychiatric patients in regional and station hospitals before official establishment of occupational therapy programs in 1945–46.

Oversea theaters

In theaters of operations, occupational therapy was, perhaps, more urgently needed and results obtained more dramatically gratifying than in the Zone of Interior. American Red Cross recreation workers and personnel of the Army's Special Services ran hobby shops and variously organized arts and crafts programs in many of the larger general hospitals. In many station hospitals, however, not even these personnel were available to conduct activity programs, and it again devolved upon the individual medical officer to utilize such personnel and material resources as he could recruit to "treat" his neuropsychiatric patients. The following is an extract from the account of how and why one medical officer made occupational therapy available to patients at a station hospital in the Southwest Pacific Area:[29]

> The subject of this letter might be called "The Rehabilitation of Soldiers With War Neuroses."
>
> What happens to the people of a country like the United States when they get called to fight in an Army that has been hamstrung, held down, undertrained, poorly supplied, and ill-equipped because the people of the United States lacked the foresight and backbone to see what was coming and back up the President when he tried to do something about it? Well, they get drafted awfully fast, they don't get much training and they go overseas fast as hell because if they didn't there wouldn't be anybody at

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[28] In 1944, Shulack pointed out: "It is not generally known that hospital funds may be used to assist in this field, but following is an extract from AR 210–50, par. 4a, which clearly indicates: 'Hospital Fund: Object—To supplement the activities of supply services in contributing to the comfort, pleasure, contentment and the mental and physical improvement of the sick in the hospital to which the fund pertains * * *.'" *See* Shulack, N. R.: Occupational-Recreational Programs in Neuropsychiatric Sections of Army Station Hospitals. War Med. 5: 109–116, February 1944.

[29] Personal letter from Capt. Charles E. Test, MC, 126th Station Hospital, San Francisco, Calif., 7 Oct. 1944 (recipient unknown).

all to handle the military situation * * *. That's why trained machinists, concert pianists, great authors, skilled chemists, university professors, and thousands of other specialists end up in the infantry carrying a gun instead of in a job suited to their qualifications.

They didn't even have time to train these soldiers properly in 1942, or to give combat troops firing practice they should have had. And this is what happened. Those men sweated it out in the SWPA [Southwest Pacific Area]. They went into battle over the Owen-Stanley Range, carrying their equipment on their backs. They made frontal assaults on prepared Japanese positions, and in lots and lots of cases after the day's combat mission was over, a rifle company ended up with a second lieutenant or even a buck sergeant in command—every other company officer and noncom [non-commissioned officer] was killed or wounded or missing * * *. The pilots flew mission after mission in planes that didn't contain a single original part—planes put together piece by piece out of salvaged parts—they call that "cannibalizing." I watched them do it. And they did it when they were sick. When they, too, had anemia, and temperatures up to 103, and all the rest of it. And the older men—35 to 40 years old—too old for the Infantry even in those tough times—they unloaded the ships in New Guinea—24-hour shifts, no time off, and lots of them had double hernias, varicose veins, arteriosclerotic heart disease, etc., etc. I took care of lots and lots of those men * * *.

And here's what happened. A good many of those men cracked up—they got so they couldn't stand the sound of an air-raid siren, they crawled under the bed screaming when the "ack-ack" started, and they got so tremulous they couldn't write. They became so irritable you couldn't live with them; they got recurrent, persistent headaches, dizzy spells, low back pain, functional nausea and vomiting, anxiety neuroses, full-blown conversion hysteria, and every other symptom and sign of an insoluble, unconscious, unbearable mental conflict that you can think of.

* * * the Colonel decided that men with mental disabilities could be better treated, better diagnosed, and more of them sent back to duty of one sort or another if they were sent to specialized, neuropsychiatric hospitals, where the professional staff from the commanding officer on down consisted of men with psychiatric experience. No such hospital existed in the Army, so he took ordinary hospitals, relieved all the surgeons and internists, and replaced them with psychiatrists. He also decided that it would be a good idea if the patients in these hospitals had a little something to do, to keep from lying in bed all day and thinking about their symptoms, and to give them a chance to do something useful. * * * build up their ego a little—give them a sense of accomplishment, and prove to them that they weren't useless to the Army and to themselves as they might think. So he arranged for these hospitals to have a little extra equipment—some picks and shovels, rakes and hoes, and seeds—so they could plant a garden and get some fresh vegetables to eat; and some hammers, saws, and planes so they could build a few trinkets, or maybe even some furniture the hospital could use. In November 1943, he told me that he wanted me to plan and direct such an Occupational Therapy program in one of the Neuropsychiatric Hospitals he was then in the process of organizing.

So I did. And I've learned an awful lot in the process, just since May 13, 1944. First of all, I learned that it was hard to convince the average psychiatrist that Occupational Therapy was anything more than basket weaving. And I learned that it was hard to get the patients interested. They like to play baseball, but they didn't think much of digging in the garden, and at first they didn't think much of doing any work in the carpenter shop, until they learned that the only way they could avoid having to keep all their toilet articles on the ground was to go down to the shop and build themselves a bedside table.

I began to get some results too. One or two patients who had been given up for lost by the ward officer made apparently complete recoveries when they found some-

thing—some activity—some field of interest, suited to their abilities * * *. As Karl Menninger puts it, they learned how to play.

I found that it took a wide variety of activities to satisfy the interests of our varied patient population. And they began to show a little more enthusiasm for the program. I had to get more hammers, saws and planes for them; I had to get some old broken-down trucks for the automobile mechanics to work on, a transit and some marine engines for the boys from the Amphibious Engineers to work on, a transit and some draughting instruments for the men who had had some experience or interest in that line. I had to get power saws so they could build furniture for the hospital more easily, and faster.

The patients love it. Six of them lay on their backs in the mud every day for a week rebuilding a * * * truck—someone had made them mad by saying it couldn't be rebuilt. We use that truck every day now. After the Ordnance vehicle inspector looked that rebuilt truck over, he sent us out two jeeps to work on. And every bit of that work was done by neuropsychiatric patients.

Why do they like it, and how does it work? * * * Well, it isn't work to them—it's play. I keep it on that basis. They work on their own time, voluntarily, and when they get tired, or want to go out and play baseball all afternoon, they can. All the pressure and strain of ordinary military duty are eliminated. And they can do the kind of work they like best. I think they get a sense of security, of safety, of protection from working at the same old stuff they did in civil life. Secondly, they accomplish something—they construct something—something practical and useful * * *. They can work off some of their neurotic tension through productive activity. And they *learn* something. They get a bit of education in some subject they're interested in.

What does the Army get out of all this? Well, it helps to get the patients well, and conserves manpower in this theater. A limited amount of repair work on Army equipment and vehicles which would otherwise be scrapped is accomplished. Patients who need reassignment or reclassification are trained for their new jobs and given practical trials in them. The psychiatrist gets a chance to observe their behavior under conditions much more like the real world than the ordinary hospital presents.

I think that probably the biggest reason why such a rehabilitation program works is that most of our soldier patients aren't as sick as we used to think they were. Their illness is due more to situational factors than to unconscious emotional conflicts. They don't need deep or drastic psychotherapy—all they need is a chance to relax, a little understanding of their problems, something to get interested in, a goal they can reach, and a chance to start over again—a fresh start in a new job, either in or out of the Army.

Specialty Hospitals

Mason and Darnall General Hospitals were designated as specialty hospitals of neuropsychiatry. Primarily, these were for the care of psychotic patients, but some patients with severe neurotic reactions were also admitted. Mason General Hospital housed more than 3,000 patients and Darnall General Hospital provided for almost 1,000.

Since the occupational therapy service at Mason General Hospital was, in every respect, one of the most extensive in the Zone of Interior, a summary of its growth and development is included here.

One of the psychiatrists at Mason General Hospital outlined the status and function of occupational therapy at that hospital in the following manner:[30]

[30] Cotton, H. A., Jr.: Reconditioning Neuropsychiatric Patients in the Army. Mil. Surgeon 97: 453-454, December 1945.

TABLE 65.—*Occupational Therapy Program at Mason General Hospital, 1944–45*

Month	Facilities/Equipment/Supplies	Personnel	Patient census	Activities/Innovations
January	One large shop with a few basic woodworking tools. Activities included woodworking, art and jewelry. The OT Section was a compound of the Neuropsychiatric Service.	8 enlisted men and 1 WAC.	600-700 open ward patients assigned daily to industrial therapy. Approximately 60 patients (mostly open ward) assigned to shop.	Industrial therapy assignments involved hospital details such as wards, mess office and hospital maintenance. All assignments had medical approval.
February	Initial equipment unpacked, inventoried and stored. Storeroom and office established. System of tool-checking devised for protection of patients.	Senior therapist assigned.	Referral of closed ward patients to OT initiated.	Industrial therapy innovations: basic instructions compiled and made available to ward officers and nurses; weekly progress reports on patients initiated; a daily consolidated report of patient placements throughout the hospital maintained. Closed ward patients stained 300 pieces of ward furniture (cubicles, shelving, etc.).
March	Improvements made in workshop by Post Engineers. Standard shelving for storeroom completed.	Staff therapist added and put in charge of workshop.	Prescribed patients increased to 110. Industrial therapy assigned a daily average of 383 patients.	

TABLE 65.—*Occupational Therapy Program at Mason General Hospital, 1944–45*—Continued

Month	Facilities/Equipment/ Supplies	Personnel	Patient census	Activities/Innovations
April	Red Cross craft equipment used to supplement existing OT supplies.	4 EMs transferred out of section. 2 staff therapists assigned.	Industrial therapy assigned 363 patients daily.	The School of Military Neuropsychiatry became responsible for its own industrial therapy program. Monthly assignment sheets stabilized patients' assignments.
May	----------	Staff OT added to assume responsibility for industrial therapy program. Gray ladies assigned to the workshop.	Industrial therapy assigned 435 patients daily. POW wards enrolled 11 patients in OT.	Occupational therapy instituted on the German Prisoner of War ward. Due to lack of detachment personnel, 12 new jobs for patients were established.
June	A second shop was opened for "sedative" crafts (leather work, art, ceramics and weaving).	----------	Industrial therapy assigned 470 patients daily (only 100 of these being open ward.) Workshop attendance was 200 patients per week.	
July	----------	New staff OT assigned.	Total patient census in 2 workshops was 504.	Work therapy transferred to Reconditioning. Emphasis placed on patient projects vs hospital work. The CO approved a RX and Progress Report Form. OT discontinued for POWs and started on female ward.

TABLE 65.—*Occupational Therapy Program at Mason General Hospital, 1944–45*—Continued

Month	Facilities/Equipment/ Supplies	Personnel	Patient census	Activities/Innovations
August	----------	4 EMs, 2 WACs, 1 apprentice OT and 1 Red Cross Arts and Skills sculptress assigned.	Total patients treated: 808.	An exhibit for the Office of War Information was prepared for oversea consumption.
September	----------	1 WAC assigned.	Total patients treated: 715.	OT cooperated with Special Services on 2 patient projects: a puppet program and an all-patient play for which OT directed the making of props, costumes, scenery and the printed program.
October	1300 lbs. of aluminum contributed by Republic Aviation Corps and 500 lbs. of self-hardening clay and glazes donated by Arts and Skills Corps.	2 EMs assigned.	Total patients treated: 888.	The painting of murals as a patient project for decorating the Red Cross Recreation Hall was approved by the Commanding Officer and the project begun.
November	Two OT shops opened at the Edgewood Division.	2 Arts and Skills Corps members assigned.	Total patients treated: 1,302.	The OT Section began the two-month training period for four students of the War Emergency Course.
December	Donations of running supplies received.	2 EMs and 1 WAC assigned to Edgewood.	Total patients treated: 1,166.	The Red Cross Recreation Hall murals were completed and hung. Major monthly activity was directed toward establishment of the OT Program at the Edgewood Division.

TABLE 65.—*Occupational Therapy Program at Mason General Hospital, 1944–45*—Continued

Month	Facilities/Equipment/Supplies	Personnel	Patient census	Activities/Innovations
Summary for 1944.	At both the Brentwood and Edgewood Divisions, there were: 2 large shops, 1 office, 1 storeroom.	1 Senior OT, 4 staff OTs, 5 Appr. OTs, 8 EMs, 4 WACs, 1 Secretary, 6 Gray Ladies, and 6 Arts and Skills Corps members daily.	Average daily treatments at the two divisions: 200 patients each.	
Summary for 1945.	Additions to Brentwood Division in July: greenhouse, photographic lab and typing room; to Edgewood Division in August: large art and ceramic shop. Supplies and equipment were made adequate through use of 3 channels: increasing T/E levels in supply catalog to meet higher requirements of specialty hospital; weekly truck deliveries from Reconditioning Surplus Warehouse at Camp Upton; receipt of expendable and nonexpendable donations from several community agencies, Red Cross and the Hospital Council.	Losses due to medical discharges, overseas assignments and transfers: 5 civilians, 4 WACs and 24 EMs. Civilian craft instructors employed to compensate for EM losses. 75 students of War Emergency Course trained. Arts and Skills Corps reorganized and numbers increased to 25 daily.	Range of patients treated: 333–760, with daily average for the year of 534.	Ward work was instituted on the medical-surgical-psychotic ward in April and on the shock treatment wards in May. This served the double function of treating shock and suicidal patients, there-to-fore inadequately covered, and of extending student training to include experience with very ill patients. New activities made available to patients included photography, metalwork, ceramics, modelmaking and typing; and the level of craftsmanship was far superior to that previously offered. The student training program in occupational therapy was the largest in the country.

Source: Compiled from Annual Report, Mason General Hospital, for the year 1944, pp. 79–83, and for the year 1945, pp. 4–6.

Occupational therapy is one of the oldest and most valued forms of reconditioning for psychiatric patients. The work is carried on under the supervision of a staff of registered occupational therapists who have received special instruction and are familiar with the problems of the nervous and mental disorders which they are called upon to treat. Facilities include several large and well-equipped shops with a wide range of activities and projects.

Patients are assigned to Occupational Therapy on the basis of prescriptions signed by medical officers. The Occupational Therapists are given complete information as to the diagnosis, treatment indicated and results desired. Reports as to the patient's progress and reactions are rendered to the ward officers for incorporation in the medical records.

Table 65 presents highlights of the occupational therapy program at Mason General Hospital for the years 1944–45.

In the "History of the Reconditioning Service, Mason General Hospital, 1943–46," major problems and accomplishments were evaluated as follows:

The Occupational Therapy section at Mason General Hospital at its height offered medical treatment through supervised craft work to over 900 patients per day. The figure, 900, represented roughly one-third of the total number of available patients and was achieved when the hospital was carrying its greatest patient load. Thereafter, through the dropping of the hospital census, the average coverage since August 1945 has fluctuated between 50 and 60 percent of the total hospital census per day. Remembering that not all patients were well enough to receive treatment every day, the total percentage of patients reached by the section was probably much higher than 50 percent * * *.

The building of such a department has of necessity entailed many problems. Major among these problems are the following: Physical equipment (including space and tools), Expendables, Coverage, Personnel and Patient Approach. Each will be considered in turn.

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Space requirements for Occupational Therapy are inevitably high. Fortunately for this section the hospital administration recognized this fact early. The section was consequently in a state of constant expansion until February 1946.

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Variety and quantity of tools are essential to the smooth operation of an Occupational Therapy section. * * * Original issue of Occupational Therapy equipment was made in February 1944 on the basis of a supply list originated by the Surgeon General's Office. Tools so issued were inadequate in both quantity and quality and the list was cancelled on 1 July 1944. It was replaced the following February (1945) by MED 10–23, the current Occupational Therapy Supply List. The majority of the items on this list were doubled, and in some cases items were multiplied by as much as six. In the interim period between July 1944 and February 1945, some equipment source had to be found, not only to replace broken items but to fill gaps in the original list. The two sources tapped most frequently and most successfully were donation and surplus * * *

Even more important than physical equipment are expendable supplies. Basically there must be a constant flow into the department of standard expendables in sufficient variety to allow not only for normal needs but also for experimentation. The same list for tools which expired in July had contained the allotment for running supplies, and the loss of expendables was extremely critical. The solution to this problem was akin to that of the non-expendables. When MED 10–23 came out, the allotment level was raised to about four times the normal level for the general hospital. Quantities

of supplies were obtained from Camp Upton * * * local airplane companies (and) the Arts and Skills Corps * * *. Finally, during the last year, hospital purchases have been made for the section * * *.

Patient coverage was a source of deep concern to the section until June 1945. It was essential that the organization be such that all patients could potentially receive Occupational Therapy if they so desired. Until May 1945, the shops were the only avenue of reaching the patients. Although the patient load was high, there were, nonetheless, many patients, particularly shock treatment patients, who were too ill to be treated in the shops which allowed liberal and free use of tools. In May 1945, the Chief of the Neuropsychiatric Service consented to the establishment of a ward program for shock treatment patients on a nontool basis. This program was tremendously successful and eventually expanded until it covered eight wards * * *. Such a program served as a splendid introduction to Occupational Therapy, not only to those patients who became better and eventually came down to the shops, but also to members of the detachment whose understanding of the department's purpose had theretofore been somewhat limited.

The problem in personnel arose from the allotment of therapists through the Surgeon General's Office. The quota, as established, was one therapist to every 250 patients in the general hospital. The general hospital will, out of every 250 patients, have 25 to 30 patients whose conditions are such that Occupational Therapy is indicated. One therapist can well handle such a number. Mason General Hospital, however, was an all-psychiatric hospital, and as such potentially all patients were eligible for Occupational Therapy. No rise in quota was ever formally allowed. Supplementation was necessary. Sources were three—military, voluntary, and civilian. Enlisted men were assigned from Headquarters whenever possible. Assignment was on the basis of skilled trades such as carpentry, photography, jewelry, and gardening. These men were, for the most part, a transient group but their assistance at all times was greatly appreciated. Members of the WAC were also assigned. These young women attended a training class for O.T. Assistants given at Halloran General Hospital. They were a more stable group and were of great value. Voluntary assistance at first came from the Gray Ladies and later from the formation of an Arts and Skills Corps by the Red Cross. Skilled artists from the surrounding territory volunteered their services for one day a week * * *. The civilian source had two facets. The Army, finding the number of therapists inadequate for its needs generally, instituted the War Emergency Course for Occupational Therapists, students of which were trained at this institution. Not enough can ever be said in praise of those students. The number of students trained at Mason General Hospital was sometimes as high as 25 at a time. These young women made possible the ward program. They filled all the instructing gaps. They were more work for the section, but they paid ample dividends. * * * When the student training program ended, the discharge criteria for enlisted personnel had been established and the hospital hired and trained civilian instructors to fill vacancies * * *.

A few words should be said about the Occupational Therapists who have been at this hospital for the last year. It is an exceptional staff and it should well be for it was selected from the hundred odd students who were trained at this installation.

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The neuropsychiatric hospital has a particularly difficult problem to consider in its approach to patients through Occupational Therapy. "Medicine" per se is an unattractive thing to the average patient and to "have" to make something makes most psychiatric patients rebellious. Solutions to this problem were numerous. The first was in attitude. No patient was ever forced to participate in Occupational Therapy. All patients, however, were encouraged to participate. The shops were attractively decorated and the atmosphere in them was uniformly friendly, hospitable and gay. The second was craft selection. An attempt was made to institute crafts

which would be of natural interest to the patients. Crafts used were: carpentry, jewelry, plastics, printing, typing, photography, ceramic, stenciling, art, weaving, and leatherwork * * *. The technique of suggestion was used at all times to direct the patient into the right craft for him but no formal medical "treatment" concept ever reached the surface of the shops' activities.

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The principal source of problems to Occupational Therapy at Mason General Hospital lay in the disproportion inevitably created by applying standards for the ordinary general hospital to an all-psychiatric hospital. In time, however, to all these problems some solution was found * * *.

In retrospect, the following comments[31] further elaborate upon the treatment data, already discussed, with additional remarks evaluating achievements in the specialty program at Mason General Hospital:

First, it should be noted that the preceding quoted comments were written in December 1946, when Mason General Hospital was deactivated. They were set forth for a reading public presumed to be thoroughly familiar with the Army medical program in general and in particular with the participation of Mason General Hospital in that program. Thus, no mention was made that Mason General Hospital, in addition to being a treatment center, was also a reception-classification-redistribution center for neuropsychiatric patients. Because of this additional designation, there was at all times in the hospital a percentage of patients whose stay was too short to permit definitive treatment. Although an occupational therapy program for such patients was initially attempted, it could be little more than a general activity program and soon proved to be impractical. In consideration, therefore, of this constantly shifting component of the overall hospital census, the percentage of patients who were eligible for treatment and who did receive occupational therapy was actually higher than the report indicated.

Remaining comments on the Mason General Hospital program can be divided into three areas relative to treatment, educational, and administrative functions of the occupational therapy staff.

With reference to patient treatment, the therapists reversed some traditionally restricting procedures and added new concepts to professional practice. The first of these was their demonstration that neuropsychiatric patients need not be prohibited from using tools appropriate to the activities in which they were engaged. With adequate protection and supervision and with accurate tool checks, the therapists learned that almost any tool could be used in occupational therapy. This was a calculated risk, taken as such with the full knowledge and consent of the psychiatric and administrative authorities of the hospital and it worked. "We had, out of all the thousands of patient treatments, only one serious accident—an attempted throat slashing by an extremely suicidal patient. The patient lived, so actually we had no casualties." Obviously, occupational therapy

[31] Personal communication, Dagny Hoff Roseboro, Chief Occupational Therapist, Mason General Hospital, to the author.

programs with shock treatment and locked-ward patients were more limited, but not drastically so, and such restrictions were dictated by the needs of the patients and not by an overall protective regulation. With this free use of tools, there was created a nonprohibitive working environment, and the evils of a restricted activity situation were avoided.

Another reversal of traditional treatment function came about when the chief occupational therapist insisted on removal of the industrial therapy program from the jurisdiction of the Occupational Therapy Department. In her opinion, the "use" of this program was obvious but its therapy very dubious. Furthermore, it was believed that (1) little in the education of the therapist was preparatory for conducting the type of industrial program which was carried out at Mason General Hospital, and (2) not all of the 800 patients listed on the daily roster of this program could be appropriately "treated" by assignment to the available activities.[32]

An area in which the occupational therapy staff of Mason General Hospital obtained possibly better-than-average success was that of reporting on patients. Digested references to their regular, comprehensive, and treatment-centered reports frequently appeared in the medical records, and when time permitted, staff members attended and reported verbally at conferences. With the unusually large patient population at Mason General Hospital and the consequently reduced opportunity for the psychiatrist to know individual patients, this reporting function may well have assumed greater importance than in the average psychiatric hospital.

Finally, perhaps the most significant advance in treatment concept was made in the occupational therapy staff's reemphasis on use of self in treatment, as follows:

> We learned to take hold of a patient where we found him and to move him, with professional guidance when we needed it, in the direction we wanted him to go. Nor did we do this by crafts and activities alone. We also learned to use ourselves and our auxiliary personnel (enlisted men and women, civilian employees and various volunteers) for our own health-giving qualities and I often assigned patients to given activities being handled by specific people because of an effect needed by the patient. The effect was a total effect in which the personality of the well person was of paramount importance. Although some of our colleagues seem to feel that this is new, I personally feel that it's as old as occupational therapy itself and the only thing that is "new" about it is the emphasis.
>
> An application of this could be found in the selection of our staff. I added only therapists who amplified a central OT personality or core; I selected them with reference not only to the department's needs but also with reference to their own needs. It was this which made them such a successful group. Separately, they were wonderful women but together they formed a unit which was unbeatable. To outreach themselves was normal for them. They were strengthened by each other. And of course, when we separated, each person fell back to his own basic personality with a real sense of loss. This was not such an unusual experience. Counterparts can be found in military and navy experience throughout the whole war. Carlson's Raiders are one example.

[32] These points concerning the misuse of industrial programs and the lack of preparation of the occupational therapist for their supervision have been noted by others and have a degree of validity. It is only fair, however, to point out that such has not always been, nor does it need to be, the case.—W. L. W.

In educational activities, therapists at Mason General Hospital were also extremely active. They lectured regularly to the Army's School of Military Neuropsychiatry, which was located at the hospital, and were thus able to orient large numbers of medical personnel who were subsequently assigned to other hospitals. The house staff were kept apprised of occupational therapy functions by oral and written reports on patients they referred. Constant effort was directed toward the inservice training of the Occupational Therapy Department's own staff, including therapists, enlisted personnel, volunteers, and students. The occupational therapy program was the largest conducted in any Army hospital and included extensive course outlines for formal lectures and demonstrations as well as planned applicatory experiences during the period of clinical affiliation. There was also lay education achieved by the considerable publicity devoted to military medicine in general and Mason General Hospital's psychiatric program in particular. For example, Walter and John Huston's documentary (the film, "Let There Be Light") on psychiatric casualties was partly filmed in Mason General Hospital's Occupational Therapy Department and used their personnel.

One final achievement must be classed as administrative. This was the transfer of occupational therapy from the jurisdiction of the Reconditioning Service to that of the Neuropsychiatric Service. Although there was much discussion during the war (and has been since) on both sides of this question of the administrative placement of occupational therapy, its reassignment in this instance permitted its greater use as a therapeutic agent.[33]

IN RETROSPECT

As was noted in the opening sentence of this section on occupational therapy, it was the intent of the author both to summarize and to evaluate the role of this treatment adjunct of military neuropsychiatry. It is therefore assumed that the reader has been left with a firm idea that although many laudable efforts were made, on both central administrative and local clinical levels, to overcome obstacles to program development, many major problems were solved only after the war had ended.

Thus, for the perfectionist and the too-ready critic, the story of World War II occupational therapy might be dismissed with the comment "too little and too late." A better summation, however, would indicate that such a comment could characterize many aspects of the war itself and, thus, of the medical services. One has only to reflect on Captain Test's

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[33] Mason General Hospital was not alone among Army hospitals in effecting this local reversal of central policy. Several other general hospitals made similar shifts in assignments which made the Occupational Therapy Department responsible, for treatment, to the Medical Service where patients of that service were concerned, and for administrative purposes, to the Reconditioning Service. These included hospitals designated as centers for the treatment of orthopedic and neuromuscular conditions as well as those designated as neuropsychiatric centers.—W. L. W.

commentary on the general overall unpreparedness (p. 672) to understand that serious problems were also inevitable in occupational therapy, for which solutions could only tardily be found.

One other point of evaluation, concerned more with the quality of professional philosophies and procedures than with technical handicaps of personnel, space, and supplies, has heretofore been only briefly mentioned, and this merits additional comment. This is the inference from the record that occupational therapy programs were far more concerned with the activities engaged in and projects made by the patients than with the dynamic mechanism and therapeutic effect of these on the patient and his disease process. In fairness to the occupational therapists, trained primarily to carry out the orders of the physician's prescription, at least a portion of the blame for this rather literal application of their services to treatment of the patient must be borne by the referring and supervising psychiatrists. It should be also noted that, until nearly the midpoint of the war, psychiatry was only a branch or section of the medical service. This virtual stepchild relationship to medicine as a whole was reflected as much in its at first unimaginative and limited use of adjuncts, such as occupational therapy, as in its own physical location, traditionally, at the end of the last ramp on the most remote wards of the hospitals. After 1943, when psychiatry was elevated to equal status with medicine and surgery on the tables of organization of Army hospitals, there were increasing instances of a more dynamic psychiatry and thus of more insightful use of occupational therapy.

Conversely, in fairness to psychiatrists, there are occupational therapists, in both military and civilian practice today, who tend to credit Army psychiatric personnel and programs with changing concepts and practices in contemporary occupational therapy. Among present-day emphasis in patient services, for example, are the selection of activities with greater reference to individual patient needs, and the therapeutic use of self and group techniques and the multidisciplinary approach to patient treatment. That some of these current developments came from seeds planted in the military hospitals seems credible for several reasons, as follows:

1. Prewar occupational therapy consisted largely of understaffed, overcrowded, activity-centered programs for female patients or for deteriorated, chronic male "psychotics." Weaving and basketry were the symbols of practice. Increasingly, today, occupational therapy is an integral part of admission and acute treatment services, of day and night hospitals, of halfway homes, and of mental hygiene clinics and other outpatient facilities. More specific individual and group techniques are demanded by the psychiatrist, and a more realistic scope of vocationally related activities characterizes the modern treatment program.

2. Group therapy, rarely applicable with the regressed schizophrenics who made up such a large proportion of the pre-World War II psychiatric hospital census, was successfully used with the large numbers of acutely

ill patients seen in Army hospitals more immediately following onset of neurotic or psychotic symptoms. One hospital,[34] for example, reported the following:

> Group therapy was continued as a very necessary part of the program because of the overwhelming patient load. It became apparent, however, that a standardized method for all therapists in the hospital should be written in order to insure a uniform quality of therapy. Accordingly, a manual was organized and distributed which contained specific instructions for the carrying out of an adequate group therapy program for the type of patients treated at this hospital.

Use of these techniques, essentially new to occupational therapists, particularly in conjunction with other professional groups (for example, psychologists and social workers) serving the patient, was unquestionably a growth-producing factor in the history of this profession's development.

3. The all-important aim of the Army Medical Service—to get the patient back to duty or at least out of the hospital to make room for ever-mounting admissions—exerted pressure for maximum utilization of treatment services. To provide additional personnel for such services and also to guard against the potential danger of women working with acutely ill and disturbed patients, common practice was to assign corpsmen to occupational therapy. These enlisted personnel filled other than guard roles, many of them bringing to the section manual skills in the more "masculine" activities appropriate to the military setting. It is believed that their extensive utilization in Army occupational therapy programs paved the way for recognition and certification of civilian assistants and aides, which was established by the American Occupational Therapy Association.

That these and other supposed influences on occupational therapy might have occurred without or aside from the military experience is a legitimate hypothesis. That the wartime experience of occupational therapists who witnessed the effect of more dynamic use of activities and of psychiatrists who challenged them and others to evaluate critically and subsequently improve their service was also a factor seems an equally reasonable possibility.

Past and present aside, however, the future may perhaps be viewed with more assurance than speculation. If prepared in no more than the areas which proved to be major bottlenecks in World War II, occupational therapy history, if consulted, should provide a head start on program development in the event of future need. First, future guidance would certainly consider training for top priority to be started early enough to insure availability of qualified personnel to carry out programs. Second, both trainees and graduate personnel should be included within the military framework in order to facilitate recruitment and assignment of personnel. Third, there is extensively recorded experience with the types and levels of supplies and equipment essential to servicing given numbers

[34] Annual Report, Welch Convalescent Hospital, 1945, p. 18.

of patients and clinical conditions and with the importance of making these accessible through Army channels. Fourth, there exists a file of architects' blueprints, for remodeling or new construction, which include special requirements for occupational therapy in military hospitals.

Finally, it is hoped that in a parallel future situation, occupational therapy will be given the opportunity to prove that it has a place in oversea or in theater of operations hospitals. Such value was proved in the World War I experience of reconstruction aids serving with the American Expeditionary Forces in France, has since been attested by the recorded experience of numerous military personnel serving in oversea theaters in World War II, and is logically substantiated in this concluding quotation: [35]

> The use of occupation exclusively or primarily for the sake of its therapeutic value represents an indispensable aid in the management of neurotic, psychotic, as well as of all convalescent patients. Occupational therapy should be applied at all points of treatment from forward echelon aid station to the last point of evacuation in the psychiatric section of a named general hospital. As soon as the removal from immediate danger, a good meal, a clean bed, a sedative, and the ministration of a nurse have allayed the acute mental upset, the soldier should be directed to some useful work in the interest of the group in which he finds himself. Overly sympathetic and protective attitude on the part of medical officers and attendant personnel, while the patient remains idle, leads to further slackening of his morale and a tendency to morbid introspection. On the contrary, when given something interesting or useful to do, the feeling of personal worth is enhanced and the desire to be well again and to join the group in unselfish striving towards a common goal is stimulated.

[35] Barton, Walter E.: Occupational Therapy. *In* Manual of Military Neuropsychiatry. Harry C. Solomon and Paul I. Yakovlev (editors). Philadelphia: W. B. Saunders Co., 1944, p. 605.

CHAPTER XXIII

Reconditioning of Psychiatric Patients

Colonel Edward F. Quinn, Jr., MSC, USA (Ret.)

BACKGROUND

Before the spring of 1944, the official attitude of the Army "toward psychiatric illnesses was a mixture of fatalism and disinterest; treatment was discouraged."[1] In fact, AR (Army Regulations) 615–360, 26 November 1942, specifically denied definitive treatment for psychiatric patients. On 15 December 1943, Changes No. 16, to AR 615–360, stated that patients with conditions incident to service, after recovery within a reasonable period of time (presumably with or without treatment), could be returned to duty. Liberally interpreted, this meant that psychiatric patients, if treated and rehabilitated within a reasonable period of time, could be returned to duty. However, many psychiatric patients, regulations notwithstanding, had, before this time, received some sort of treatment.

Occupational therapy and recreational diversional activities, used in civil hospitals for many years, had been introduced into the Army hospitals with the civilian psychiatrists and the American Red Cross arts and crafts and recreational workers. In the Army, these civilian psychiatrists, now military officers, soon discovered that disposition procedures were frequently long drawn out affairs, especially for psychotic patients recommended for transfer to State hospital care. They, therefore, attempted some measure of treatment so that these patients as well as those with severe neurotic tendencies could be sufficiently improved to be discharged to their own custody or to that of immediate relatives, thus materially speeding up the process and freeing much needed beds. There were no official directives or standards to insure uniform methods of treatment so that any treatment given varied not only from post to post but also from psychiatrist to psychiatrist.

EVOLUTION OF RECONDITIONING

The reconditioning of psychiatric patients, and, for that matter, the entire reconditioning program, was an evolutionary process and a collective effort. Born of necessity to conserve manpower from an administrative

[1] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 293.

standpoint, and for that and other more subtle reasons from a psychiatric standpoint, it became in reality a combination of the diversified efforts of several professional media to rehabilitate the sick and injured.

Convalescent Programs Authorized

Late in 1942, military and civilian opinions were being expressed relative to the development of special accommodations for convalescent patients. As an aftermath of such discussions and opinions, the War Department, on 11 February 1943, issued WD (War Department) Memorandum No. W40–6–43, which authorized convalescence and reconditioning in hospitals. Although the convalescence program actually proceeded faster than the reconditioning program, there had been and there followed some effort in reconditioning and rehabilitating patients, including those with psychiatric problems.[2] "On 21 June 1943, ASF Headquarters approved the program The Surgeon General presented," [3] recommending the use of convalescent programs. Occupational therapy was in prior use, especially for psychiatric patients. It was officially authorized for general hospitals on 12 August 1943, with the issuance of Circular Letter No. 149, Office of The Surgeon General, U.S. Army.

Reconditioning Programs Authorized

More than a month after occupational therapy had been officially recognized, and 3 months after the convalescent program had been approved, The Surgeon General, in Circular Letter No. 168, 21 September 1943, prescribed a convalescent reconditioning program for general hospitals. The prime objective of this program was to return recovered medical and surgical patients to duty in the best possible condition. At this time, however, there were no provisions to include psychiatric patients in the program.

Apparently, the program did not develop as rapidly as was desired because, on 10 December 1943, The Surgeon General issued Circular Letter No. 203, by which all service command surgeons and commanding officers of all general hospitals were directed to establish reconditioning programs without delay; further, that all patients be included whether or not they were expected to return to duty. Psychiatric patients in general hospitals were mentioned, but they were to be placed in specific centers or on special wards; they were not to be intermixed with other patients.

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[2] Pilot studies at England General Hospital, Atlantic City, N.J., at the Regional Hospital, Camp Swift, Tex., and at three ASF (Army Service Forces) replacement training centers.

[3] Smith, Clarence McKittrick: The Medical Department: Hospitalization and Evacuation, Zone of Interior. United States Army in World War II. The Technical Services. Washington: U.S. Government Printing Office, 1956, p. 120.

Reconditioning of Psychiatric Patients Recognized

It was not until 1 April 1944 that War Department Technical Bulletin (TB MED) 28, the first comprehensive directive on the treatment of psychiatric patients, was issued. This presented, in detail, various treatment procedures but did not officially include psychiatric patients in the reconditioning program. A change in TB MED 28, issued on 15 April 1944 as TB MED 32, stated, as follows:

> Except for those patients capable of returning to duty, neuropsychiatric patients are not to be included in the reconditioning program but are to be handled separately and provided with the program outlined above. There should be cooperative efforts between the two programs in the utilization of special instructors and physical facilities. Psychoneurotic patients, as a group, cannot maintain competition in the physical training of the reconditioning program, and their failure not only affects them adversely but grossly interferes with the effectiveness of the program for the individuals for whom it is designed.

Thus, as a modification of the directive, the psychiatric patients were included but with definite limitations.

Psychiatric Reconditioning Established

In the Surgeon General's Office, Maj. (later Lt. Col.) Walter E. Barton, MC,[4] a psychiatrist and the assistant director of the Reconditioning Division (later the Reconditioning Consultants Division), with the support of the Neuropsychiatry Consultants Division, directed his influence and efforts to improving the psychiatric reconditioning program. This resulted in the issuance of ASF Circular No. 175, on 10 June 1944, followed shortly therafter, on 30 August 1944, by TB MED 80. These directives detailed the reconditioning program for psychiatric patients and included "any patient who has even a remote chance for salvage for additional military service * * *."

PRINCIPLES AND AIMS

The philosophy of psychiatric reconditioning followed several basic principles:[5]

1. Regard every case as salvageable.
2. Start treatment as early as possible.
3. Avoid the hospitalization of psychoneurotics.
4. Remove situational factors if possible.
5. An individual or group approach as indicated.

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[4] Colonel Barton was originally brought into the Neuropsychiatry Consultants Division, on 17 April 1943, to develop the occupational therapy program. On 19 August 1943, he was assigned to the Reconditioning Division as Director. On 3 February 1944, Col. Augustus Thorndike, MC, was appointed as Director, and Colonel Barton then assumed the position of Assistant Director.

[5] Farrell, M. J., and Appel, J. W.: Current Trends in Military Neuropsychiatry. Am. J. Psychiat. 101: 12–19, July 1944.

6. Individual's capacities must be recognized.
7. Planned activities can serve as a trial at duty.
8. Proper job assignments are most important.

Smith [6] commented on the convalescent reconditioning program as follows:

> Convalescent reconditioning applies to all specialities but it is of vital importance to psychiatry not only because of its specific value in functional disabilities but also owing to the large number of such disabilities. Psychiatrists are fully aware of the value of a reconditioning program, and probably are better informed than most medical officers as to how it may specifically function. At some military installations a psychiatric medical officer has been appointed as reconditioning officer. In civilian life every physician who successfully treated psychoneuroses learned that treatment must be based on carefully planned purposive constructive scheduled activities. Psychotherapy was necessary, but in many cases failed to achieve results unless the work, play, rest, and exercise of the patient were organized constructively along principles of good mental and physical hygiene.

Barton,[7] in summarizing the reconditioning program, stated:

> Out of the renewed interest in the convalescent patient brought about by the necessities of war, it may be anticipated that increased attention will be given in civilian practice after the war to reconditioning. The reconditioning program begins while the patient is still in bed. A planned program of physical fitness training of educational reconditioning and of recreation has been instituted in all Army hospitals. An occupational therapy program stressing masculine interests, new activities, and useful work has been developed and coordinated with physical therapy and remedial exercise under medical supervision. Patients are removed from the over-protecting sympathy and sick-bed atmosphere of the hospital as soon as possible and segregated in a Reconditioning Unit to continue their convalescence. Progressive physical training, education and recreation are planned to direct attention from disability and illness to healthy activities that promote physical and mental fitness.
>
> Rehabilitation, which has as its objective the retraining of individuals to overcome the handicaps of disabilities, the development of self-reliance and social adjustment and placement in useful work assignment, is largely the responsibility of other government agencies. The medical department of the Army can undertake the beginnings of such rehabilitation simultaneously with medical and surgical treatments. Rehabilitation programs of the blind, the deafened and the amputee were briefly presented.

ORGANIZATION AND OPERATION

Location

As provided by TB MED 80, a neuropsychiatric reconditioning center was established in each service command in hospitals especially designated to receive patients from overseas. The overall reconditioning program, however, was authorized for all hospitals of sufficient bed capacity to make the program worthwhile. The specially designated centers in 1944 were:

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[6] Smith, L. H.: Treatment Activities in War Psychiatry. Am. J. Psychiat. 101: 303–309, November 1944.

[7] Barton, W. E.: The Reconditioning and the Rehabilitating Program in Army Hospitals. Am. J. Psychiat. 101: 608–613, March 1945.

Service Command	*Center*
First	Lovell General Hospital, Fort Devens, Mass.
Second	England General Hospital, Atlantic City, N.J.
Third	Fort Story, Va. (later Camp Pickett, Va.)
Fourth	Welch Convalescent Hospital, Daytona Beach, Fla.; and Camp Butner, N.C.
Fifth	Wakeman General Hospital, Camp Atterbury, Ind.
Sixth	Percy Jones General Hospital, Camp Custer, Mich.
Seventh	Camp Carson, Colo.
Eighth	Brooke General Hospital, Fort Sam Houston, Tex.
Ninth	Mitchell Convalescent Hospital, Camp Lockett, Calif.

Classification of Patients

For participation in the reconditioning program, patients were divided into the following four classes:

Class 4—Those who are bed patients or confined to wards.

Class 3—Ambulatory patients still requiring hospital care.

Class 2—Patients no longer requiring active medical treatment or hospital care.

Class 1—Patients most physically fit and whose return to military duty is anticipated.

Psychiatric patients generally participated in the class 4 and 3 programs in the hospital. When sent to the reconditioning section, they were usually placed in class 2 because most of these patients were returned to a limited-type duty assignment. However, those that were to be returned to duties which required the maximum degree of physical stamina were processed through the class 1 phase of reconditioning. Some patients did fail in the reconditioning program. These were returned to the hospital and appropriate action under AR 615–360 was taken.

Personnel

Trained personnel were needed for the reconditioning program, and like other phases of the psychiatric program, such personnel were in scarce supply. The personnel needed for the program included psychiatrists, clinical psychologists, psychiatric social workers, physical and educational reconditioning officers and instructors, and occupational therapists. Although efforts to recruit personnel in these categories were made, the supply never reached the demand. Therefore, in order to utilize personnel as economically as possible, the reconditioning section was established as close to the hospital as the facilities permitted and the personnel generally worked in both organizations. Enlisted assistants and instructors were specially selected by review of personnel records for people who had some of the necessary qualifications. Patients with special skills that contributed to the program were used and, at times, were actually transferred and assigned to the reconditioning staff.

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Duties.—In the administration of the reconditioning program, the duties of the various personnel were as follows:

(1) *Psychiatrist.*—

(a) Formulate and conduct the reconditioning program for the psychiatric patients in cooperation with the Chief of the Reconditioning Service.

(b) Conduct and supervise individual and group psychotherapy.

(c) Review and supervise work of psychiatric social workers and of occupational therapists, working with neuropsychiatric patients.

(d) Evaluate progress of the patients and recommend disposition.

(e) Assist in initial sorting of men and conducting sick calls.

(f) Receive reports from educational and physical reconditioning officers and instructors concerning patients' progress and advise them concerning the program.

(2) *Clinical Psychologist.*—

(a) Interview patients with regard to their skills, experience, and interests (initial questionnaire), and assist in the selection of patients who can be used as instructors.

(b) Advise the psychiatrist and reconditioning officer about the activity assignment of patients.

(c) Interview men prior to return to duty and make recommendations concerning their assignment.

(d) Administer psychometric and other special examinations at the request of the psychiatrist.

(3) *Psychiatric Social Worker.*—

(a) Interview patients for the psychiatrist.

(b) Assist in group psychotherapy under direction of the psychiatrist.

(c) Assist, when necessary, in occupational therapy, educational and recreational programs.

(d) Make recommendations concerning specific problems of individuals.

(4) *Occupational therapists and occupational therapy aide.*—To conduct the occupational therapy program as prescribed by the psychiatrist.

(5) *Physical and educational reconditioning officers and instructors.*—To carry out the physical and educational part of the program under the direction of the chief reconditioning officer with the approval and guidance of the psychiatrist.

Programs

Psychotherapy.—Individual psychotherapy because of personnel shortages and limited time was not done routinely. Special cases were referred to the psychiatrist, and if somewhat brief individual psychotherapy favored return to duty, it was accomplished. In dealing with such large numbers, group psychotherapy was a more practicable approach. Mental hygiene lectures (TB MED 12, 22 February 1944, for officers; TB MED 21, 15 March 1944, for enlisted men) and group discussions were found useful. Groups of 200 or more received these and other lectures, and smaller groups of 20 or 30 participated in group psychotherapy.

Occupational therapy.—Since occupational therapy was considered of particular benefit to psychiatric patients, it received considerable impetus in the reconditioning program. The more masculine types of such therapy were sought, but the arts and crafts were also found popular and useful. Ingenious and devious means were found to interest the patient and keep

him occupied. Group projects were often instituted such as landscape gardening, furniture and toy construction projects, camp paper publication and printing, and handyman repair services.

Education.—The educational program was directed toward several areas. Good morale being conducive to good health, efforts to improve orientation and motivation received considerable attention. The Orientation Branch, Morale Services Division, ASF, supplied the reconditioning services with considerable printed material as morale training aids. Films such as "Why We Fight" were used. War developments, the "four freedoms," war leaders, and the like, were discussed by staff and guest speakers. Even patients with combat experience were enlisted to augment these programs. "G.I." movies, 45-minute programs, which included special short subjects, travelogs, song shorts, sport shorts, and newsreels were used in a lighter vein yet nonetheless were effective. USAFI (U.S. Armed Forces Institute) courses were encouraged, and many patients subscribed to further their knowledge and education.

Recreation.—Psychiatric patients are notoriously reluctant to participate actively in competitive sports and physical recreational activities. Good supervision, planning, and encouragement usually aided in obtaining good participation. Thus, certain sports such as softball, volleyball, badminton, and certain other minor sports became popular with psychiatric patients. Competition was developed in these but the more aggressive contact sports found little interest among the psychiatric group.

Music and entertainment.—Major efforts were directed toward popularizing group participation in these entertainment fields. Group sings and bands were frequently organized for this purpose although passive participation with USO shows and guest entertainers had some therapeutic effect.

Physical reconditioning.—Ritualistic calisthenics, walks and hikes, gymnasium work, and other more routine physical activities did not find much favor, especially with psychiatric patients. It was soon learned that such activities could be made more popular if competitive features were added or the time spent in more sportlike physical activities.

Typical daily program.—A sample program for psychiatric patients [8] on a typical day was as follows:

Hour	*Activity*
0630	Reveille.
0700–0730	Mess.
0730–0800	Fatigue details.
0800–0850	Physical Reconditioning: Conditioning exercises, gymnasium work, sports, and games.
0900–1100	Education and Training Classes or Occupational Therapy; Business administration, radio, electricity, communications, automotive

[8] Barton, W. E.: Psychiatric Patient in Reconditioning Program. Dis. Nerv. System 6: 159–162, May 1945.

mechanics, woodworking, graphic arts, music, dramatics, photography, agriculture, arts and crafts.

1100–1115 ..... News analysis.
1115–1130 ..... Mail call.
1130–1200 ..... Free period.
1200–1300 ..... Mess.
1300–1400 ..... Group psychotherapy, 3 times weekly; educational hour, 2 times weekly (concerned with orientation, motivation program) guest speakers, current problems, panel discussions, military and vocational films.
1400–1530 ..... Physical reconditioning and recreation: Competitive games, sports, athletics, swimming, hiking, bicycling, and outings.
1530–1700 ..... Free period for elective activities (attendance at one compulsory). Off-duty education, language classes, technical classes supplementing shopwork, photography, music, band practice, show rehearsals, gardening, arts, and hobbies.
1715 ..... Retreat.
1730 ..... Mess.
1900–2030 ..... Entertainment: Movies, USO shows, concerts, guest entertainers, soldier shows, dances. Saturday afternoons and Sundays, open.

CONCLUSION

The concept of reconditioning military personnel was developed to ease manpower shortages, as its primary aim. Although psychiatrists were aware of the need and benefit of adjunctive therapies for psychiatric patients and had in many installations utilized these methods, no official or uniform procedures had been authorized. Initially, the reconditioning program was intended for those nonpsychiatric patients who needed further recuperation from illness or injury. The initial lay military attitude toward psychiatric patients was one of hopelessness and that any attempt at treatment was a waste of time. However, this attitude changed. Good results obtained by psychiatrists in returning psychiatric patients to duty in the combat zone, and the gradual realization by hospital commanders of what could be done with such patients in the Zone of Interior, helped break down prejudicial barriers against these patients. Thus, the all-out effort at treatment gained approval. Even patients whose physical and mental condition warranted separation from the military service eventually were included in order that they reach maximum improvement before discharge. Thus, another progressive step was made in military psychiatry.

CHAPTER XXIV

The Chaplain

Harold E. Berger, B.D.

The doctrine of religious freedom in our governmental philosophy, insured by the Constitution, is extended to every soldier in the military services. During World War II, over 70 different religious bodies were represented by 9,117 chaplains who saw service in the Army.[1]

HISTORICAL NOTE

From ancient times, the chaplain or his counterpart was associated with the warrior and soldier, lending spiritual aid to the waging of war. The manner in which this aid was presented makes interesting reading and is fully annotated by Honeywell.[2] "Religion in the modern Army is pursued, consistent with the allowances of time, location, and combat situation, and many dispensations are granted by various denominations in order that practical fidelity to military duties may not be hampered by certain religious observances cumbersome to the demands of training and combat." [3]

During World War I, as in other wars, the chaplain was frequently assigned many secular duties aside from his responsibilities for the religious and spiritual welfare of the command. "Many were put in charge of the post exchange, a mess, the unit post office, special funds, bond sales, athletics, or the schools established after the cessation of hostilities." [4] World War II sometimes involved the chaplain in similar secular duties but to a much lesser extent than in the previous war. Such duties were usually of an emergency and temporary nature. The chaplain in this war was required to include and explain, in his monthly report, all secular duties he had performed. Unwarranted assignment to other than his more normal duties was immediately corrected by higher authority.

UNIQUENESS OF ROLE

The chaplain is an Army officer whose noncombatant status places him in the group presumably protected by the Geneva Convention. But

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[1] Honeywell, Roy J.: Chaplains of the United States Army. Washington: U.S. Government Printing Office, 1958, pp. 215–217.

[2] *Ibid.*, pp. 1–10.

[3] Branham, Vernon C. and Kutash, Samuel B.: Encyclopedia of Criminology. New York: Philosophical Library, Inc., 1949, p. 251.

[4] Honeywell, *op. cit.*, p. 193.

in his status as an officer, he differs from other officers. He has access to officers and personnel in all echelons up to the highest command. This freedom of contact places him in an effective position where he can present problems, together with a solution or pertinent recommendation, directly to a level where positive action can be taken immediately.

The chaplain is actually the only person in the military who cannot be compelled to divulge privileged communications. Although the Inspector General's Department supposedly keeps communications confidential, a bona fide complaint must be investigated, and thus, confidentiality is usually lost. Privileged communications between client and attorney (judge advocate) or patient and physician (medical officer) can be abrogated under a number of circumstances.[5] So the chaplain is unique in this sphere which permits the soldier to unburden his most intimate problems in confidence. Thus, by simply listening, often without censure or even advice, the chaplain indirectly contributes to preventive psychiatry. Gregory [6] stated: "Probably the most important contribution made by the chaplain to mental hygiene and morale was an unconscious one. Their mere presence was often sufficient to give a man an assurance and confidence he would otherwise not have had."

FUNCTIONS

"Tell it to the chaplain," or "Go see the chaplain" were often colloquial jests but just as often they were meant as serious advice. When a soldier's problems, great or small, could not be resolved by the first sergeant, the company officer, or even the psychiatrist, referral to the chaplain was frequently proposed as a possible solution. This was not "passing the buck" because experience showed that many solutions were evolved.

The chaplains in World War II in all branches of the service did a remarkably efficient job of their wartime ministry. Thousands of ministers serving the churches of the Nation today are there because of the personal inspiration and incentive provided by the military chaplain. The best tools the chaplain had were his love for God and his genuine love for his fellowman. Without this background to generate his ministry, the chaplain could not succeed; without it, all other training would have been excess baggage. With it, he could be "all things to all men." He could "weep with those who weep, and rejoice with those that rejoice."

Counseling

One of the chaplain's more important functions besides his established religious duties was in the field of counseling. Some chaplains were

[5] (1) Army Regulations No. 60–5, Changes No. 1, 25 Sept. 1946. (2) A Manual for Courts-Martial, U. S. Army, 1951, pp. 284–287.

[6] Gregory, W. E.: The Chaplain and Mental Hygiene. Am. J. Sociology 52: 420–423, 1946–47.

already adept in this function, others had to learn. They frequently found willing teachers in their brother chaplains, psychiatrists, psychiatric social workers, and others. Because they did possess the best basic possibilities along these lines, they were frequently valuable assets to the psychiatrist and the "psychiatric team." They not only relieved the busy psychiatric services of many potential patients but accepted referrals from these services when it was thought that the chaplain was in a position to provide a better solution to a perplexing problem. To be sure, in some cases the chaplain was "not the desired choice" for referral.[7] Chaplains and psychiatrists alike have jokingly remarked that their "failures were referred to each other." This cliche contains much truth.

As Morale Officers

The chaplains, by their very nature, training, objectives, and position in relation to staff, not only were able to solve certain problems beyond the scope of others but also were excellent morale officers in every unit. The two major objectives which they were in a very appropriate position to accomplish were (1) the lessening of the stresses to which the soldier was subjected and (2) the increase of environmental support as it was available to them.[8] Thus, they indirectly helped in the prevention of mental illness.

The chaplain was particularly sought out in problems concerning marriage and family relations. These problems were by no means uncommon and the chaplain had the wherewith and know-how to assist in the solution of many such problems. In his advisory capacity, he was, at times, forced to request the censoring of certain books, periodicals, and features in camp shows that were morally obnoxious and obscene. He also interested himself in the rest and recreation of troops, especially overseas, in isolated areas, or aboard ships, when Red Cross assistance was limited or unavailable. The chaplain often assisted the soldier in acute, legitimate financial matters, sometimes using his own money when a Red Cross loan or Army Emergency Relief was not available.

Most clergymen are satisfied that their patient relationship has been made more effective by their awareness of two things:

1. They must be familiar with the aims and purposes of psychiatry and understand its language.

2. They must realize, and be motivated by, the unique and vital role of religion in the treatment of the patient.

The chaplain in World War II knew next to nothing about psychiatry. He left that to the man trained for and highly skilled in that profession. By means of the Sacraments and the Word of God, he was able to bring

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[7] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 66.

[8] *Ibid.*, p. 328.

comfort and hope, light and discernment, in an era when the lights had gone out all over the world. The lonely, the distressed, the frustrated could find in him a solid support. Those with burdened conscience could come to him in confidence and leave cleansed and lifted up through the Friend of sinners, Who also included them when He said, "Be of good cheer, thy sins are forgiven thee."

Soldiers turned to the chaplain with many other diverse, perplexing, and distressing problems. Nostalgia, loneliness, and a need to unburden oneself found the unfailing kindness and patience of the chaplain an ever-present haven of relief.

In the Hospital

The problems of the hospital chaplain were very much similar to those in the field but complicated by illness and injury. Under such circumstances, he probably had many more problems in the hospital setting, and he certainly found them more acute in many cases. Although the problems of the average psychiatric patient were in most instances routine, in others, they were extremely difficult and sometimes rather bizarre. It also seemed logical that "different combat arms have distinctive psychological problems which affect the chaplain's work. This is especially true of the Air Force where fighting conditions sometimes tend toward recklessness or a degree of fatalism." [9] The assumption that the chaplain solved all problems would be naive, but neither did the psychiatrist.

The acceptance of hospital chaplains has its roots in the military ministry of the chaplains of World War II. Their faithful visitation to their men in military hospitals, their eagerness to serve, to cooperate and learn, earned for them the respect and admiration of the medical men in uniform. The physicians were quick to see that the chaplain was a familiar helpful friend to the sick or wounded soldier. He instilled confidence and acceptance. He radiated Christian assurance and hope. His relationship to the patient conditioned and encouraged the patient's response to treatment. Above all, the patient knew he had a friend. Although his surroundings were unfamiliar, he was not alone. His chaplain reminded him of man's greatest Friend.

In Combat

Church services were held in combat areas wherever and whenever possible. A young sergeant, already a veteran of several campaigns, came to his chaplain and said: "Sir, I've found a new meaning and purpose in the Christian religion. Could you baptize me?" The chaplain poured water from his canteen into his helmet, the only baptismal bowl available, while the soldier kneeled on the plaster-strewn floor of what had been a tavern. In the distance, shells were exploding, the reverberations causing

[9] Honeywell, *op. cit.*, p. 250.

plaster dust to sift down upon this tiny oasis of peace. With a wave of his hand and a sincere "Thanks, Chaplain," the sergeant went on his way, fortified with the presence of Him Who said, "My grace is sufficient unto thee."

NEED FOR PSYCHIATRIC INDOCTRINATION

It has already been mentioned that the chaplain who had no previous experience with psychiatric patients needed assistance. At the time, there were no real sources where the chaplain could find material in this field which were particularly directed toward his function as a counselor. The Army Air Forces, in 1944, directed that each chaplain be given an additional 2 weeks' special training after the course at the Chaplain's School had been completed. Despite the evident need for psychiatric indoctrination, the Chaplain's manual [10] provides but little information on publications relative to psychiatry. Yet this same manual contains this warning: "A careful study of current publications, both religious and secular, is advised before the chaplain enters boldly into a field which holds so many possibilities in human personality of great good or costly error."

The care of the psychiatric patient in the Army needs the full efforts of the "psychiatric team," including the chaplain, so that if each member is fully cognizant of his expected contribution a great stride and another lessons will have been forged from World War II.

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[10] War Department Technical Manual 16–205, "The Chaplain," 17 June 1947.

CHAPTER XXV

The Technicians

Lt. Col. Charlotte R. Rodeman, ANC, USA (Ret.), Morton A. Seidenfeld, Ph. D., and *Myron J. Rockmore, M.A.*

Section I. The Neuropsychiatric Technician

Lt. Col. Charlotte R. Rodeman, ANC, USA (Ret.)

DEVELOPMENT AND DIFFICULTIES

The history of the neuropsychiatric technicians (psychiatric ward aids) during World War II paralleled, somewhat, that of the neuropsychiatric nurses. With the vast increase in the number of psychiatric patients in Army hospitals during the war and the shortage of nurses, most of the care and supervision of neuropsychiatric patients was provided by the enlisted technicians.

Very few of these men had had any previous training or experience in the care of neuropsychiatric patients, and consequently, their attitudes and approaches to such patients were governed by their own misconceptions of mental illness and their fears of and prejudices toward the mentally ill. These misconceptions and feelings at times resulted not only in neglect but also in mistreatment of these patients. It was difficult, at times, for the untrained technician to see the patient as a sick person; rather, he might see him as a fellow soldier who was "goldbricking" to avoid his military duties.

The untrained technician might not be able to consider mental illness as an illness. Such technicians have been heard stating, in very derogatory tones: "He's not sick, he's just nuts."

On the other hand, it has been the experience of most workers in the field that many technicians, even without training or experience in psychiatric wards and techniques, provided good care and devoted many hours of their own time to the care of patients, even though they may not have understood the patient's behavior. It has also been the rule rather than the exception that once the technician became aware that the patient was indeed sick his attitude toward and treatment of the patient improved. Further, when the psychiatrist or the nurse was interested in teaching the technician psychiatric care, the technician almost invariably became very

interested in the patients and sometimes became a dedicated person, making every effort to provide good care (figs. 58 through 63).

Experienced psychiatrists and psychiatric nurses made it a practice to set up and carry out an informal training program at their installations. Although some technicians voiced disbelief in some of the concepts taught, a change in attitude usually occurred within a few months, and many of these technicians not only gave good psychiatric care but also gave it with understanding and sincerity.

There is rather limited material available on the neuropsychiatric technician during World War II. Other subjects of more general interest occupied the limited time of authors in the related medical professions. Excerpts from annual and quarterly reports from various hospitals provide the only data.

ZONE OF INTERIOR

Assignment

In the Zone of Interior, while there was more formal training given, the rapid turnover in personnel in most hospitals meant that care was usually given by inexperienced personnel. As with nurses, there seemed

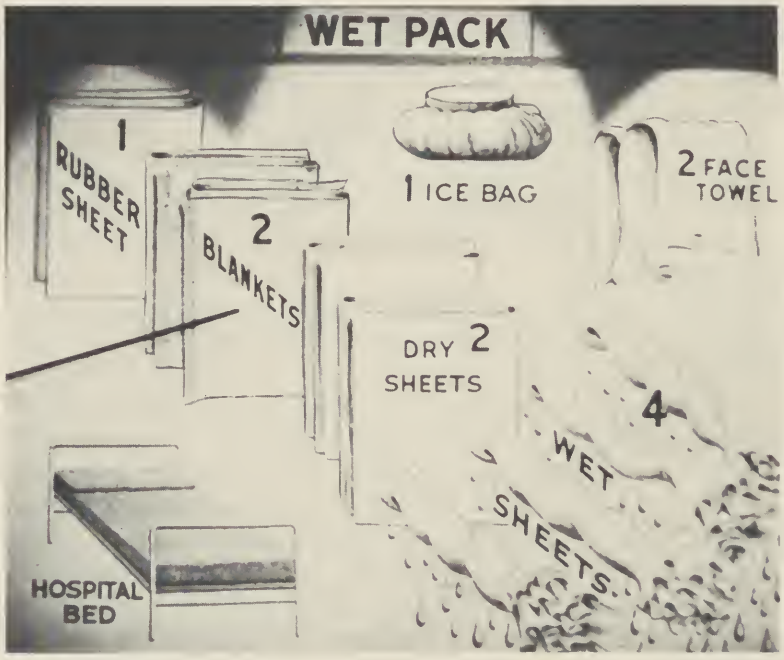

FIGURE 58.—Training chart showing materials and equipment used in the wetpack (wet cold sheet sedative pack). [From the film "Shades of Gray."]

FIGURE 59.—Neuropsychiatric technicians preparing the bed for a patient to receive a wetpack. [From the film "Shades of Gray."]

FIGURE 60.—Neuropsychiatric technicians wrapping a patient in the wetpack. [From the film "Shades of Gray."]

FIGURE 61.—Neuropsychiatric technicians securing the last blanket of a wet sheet pack. An icecap has been placed on the patient's head. [From the film "Shades of Gray."]

to be little effort to select men for this work with any regard for personal qualifications. In a number of station and general hospitals early in the war, the cadres of enlisted men sent into newly formed hospitals came from posts with divisions in training. These divisions would utilize the request for a cadre as an opportunity to transfer ineffective or undesirable soldiers. Not unknown was the practice of including in the cadre as many of the current prisoners in the stockade as possible within limits of respectability and table of organization requirements. When the cadre arrived at the new hospital, the best qualified men were placed on the surgical service while the least qualified were assigned to the neuropsychiatric service. These soldiers were quick to recognize that there were few valid distinctions between themselves and the patients. Because of a basic lack of adaptability, they gradually eliminated themselves. Excellent replacements were occasionally available by transfer from the patient population who were not able to do full field duty but were competent for "limited duty." At all times, the turnover was a problem.

Utilization and Training

An annual report [1] from Battey General Hospital, Rome, Ga., stated:

Few of the enlisted personnel had any psychiatric or hospital training. With "A Guide for Attendants in Locked Wards" utilized as a textbook, this handicap was

[1] Annual Report, Battey General Hospital, 1945.

FIGURE 62.—Neuropsychiatric technician assisting nurse with a patient in a "continuous tub." [From the film "Shades of Gray."]

overcome. Training films were shown to all groups as soon as they came on duty. These were found effective, but at all times constant direction, supervision, and explanation by the ward officer was considered paramount. Fear, prejudice, antagonism, carelessness, and a tendency to use unnecessary physical force had to be constantly combated.

At this general hospital, members of the WAC (Women's Army Corps) had 2 weeks' experience on the neuropsychiatric service as part of their medical training course. Many of them asked for assignments to the closed wards where they were utilized as nurses' assistants. They were also utilized in insulin therapy where their assistance was beneficial and they functioned quite intelligently.

The greatest problem at Mason General Hospital,[2] Brentwood, Long Island, N.Y., was the constant turnover of enlisted men, necessitating constant classroom instruction and on-the-job training to inexperienced personnel. Along with this constant shortage of personnel, which was as high as 61 percent at times, the minimum of personnel safety requirements resulted in an increase in accidents and injury to both patients and personnel and seriously affected the general morale of these personnel (fig. 64).

At Darnall General Hospital,[3] Danville, Ky., the ward attendants assigned had no previous experience and "were completely oblivious to psychiatric problems prior to their assignment here." Lectures, demonstrations, and on-the-job training were given to all men assigned, with

[2] Annual Reports, Mason General Hospital, 1944–45.
[3] Annual Reports, Darnall General Hospital, 1944–45.

FIGURE 63.—Neuropsychiatric technician, watching the "continuous tub" patient, prevents dehydration by forcing liquids. [From the film "Shades of Gray."]

emphasis on concepts of mental illness and attitudes. It was believed that training was effective "as demonstrated by the devotion of the personnel to patients under their care." One difficulty here, besides the usual loss of trained men, was the frequent assignment of men not qualified. Men returned from overseas with psychoneuroses and other neuropsychiatric diagnoses, the emotionally unstable, and completely unfit were assigned for neuropsychiatric duty. It was necessary to discharge some of these men from the service on a CDD (certificate of disability for discharge). It was believed that such assignments were detrimental both to the welfare of the patients and to other personnel. Shortages at Darnall General Hospital were frequently due to the use of neuropsychiatric technicians as escorts for patients discharged to veterans' facilities or home, but unable to go under their own care. This use of technicians as escorts, however, occurred in most hospitals.

At Valley Forge General Hospital,[4] Phoenixville, Pa., all enlisted men assigned were given careful orientation and supervised instruction on the ward with several "general talks" by the chief of neuropsychiatric service.

At Kennedy General Hospital,[5] Memphis, Tenn., a neuropsychiatric school for enlisted men was organized in 1945 to train the wardmen in the proper care of neuropsychiatric patients. This was a local arrangement

[4] Annual Reports, Valley Forge General Hospital, 1944—45.
[5] Annual Report, Kennedy General Hospital, 1945.

FIGURE 64.—Neuropsychiatric technician demonstrates one of the hazards of the neuropsychiatric ward. A patient has moistened the capsule medication and secreted it under his bedside table to take in one large dose as a possible suicidal attempt. [From the film "Shades of Gray."]

for men assigned and a total of 26 men completed the course which consisted of lectures, demonstrations, and on-the-job training.

The situation was much the same in other hospitals. Men who were trained were sent overseas and replaced by men new in the Army or by oversea returnees, many of whom were unsuitable or uninterested.

There is no record of any attempts being made to organize an authorized school for the neuropsychiatric technician. In view of the difficulty encountered in attempting to organize such a school for nurses, it is extremely doubtful if any such attempt for technicians would have been successful. However, after the cessation of hostilities, there seemed to be a greater awareness of the need for such training for technicians by the authorities, and a course for neuropsychiatric technicians was established at the Army Medical Service School at the Brooke Army Medical Center, Fort Sam Houston, Tex., in 1947.[6]

[6] This course has been revised over the years to keep up with standards and is still given several times a year to supply the constant demand for trained neuropsychiatric technicians in our Army hospitals.—C. R. R.

OVERSEA THEATERS

In Hospitals

In oversea theaters, not only the care of the patients but also, at times, the physical facilities available for patients were dependent on the interest and ingenuity of the technicians. With a minimum of equipment in the hospitals, the enterprising and interested technician frequently increased the comfort of the patient by obtaining equipment from places unknown. In one situation in the Southwest Pacific Area, a technician obtained bomb crates for use as bedside tables and various native materials for the patients to utilize for occupational therapy.[7]

Training technicians depended on the particular situation and on the interest of the physicians and nurses in such training.

In the author's situation in the Southwest Pacific Area, it was on an individual basis because there was usually only one technician assigned to the ward. Some hospitals set up formal programs, as is indicated in the reports which follow.

The 18th Station Hospital[8] in the Southwest Pacific Area gave a 6-week course in the understanding and care of psychiatric cases to all enlisted men whose duties involved contact with patients. The course was concluded with a written examination and was repeated as necessary when new men were assigned.

The 51st General Hospital,[9] also in the Southwest Pacific Area, reported that this hospital was fortunate in that "our ward men for the most part are experienced and are doing an excellent job." Here, too, lectures were given on psychiatric disorders and therapeutic procedures with emphasis on the technician and his role in the therapeutic regimen.

The 116th Station Hospital,[10] in the European theater, gave two lectures a week on psychiatric nursing as part of the routine training for all enlisted personnel during June 1944.

There is no indication of training in the reports of hospitals in other theaters, but it seems that the neuropsychiatric technicians, despite severe shortages in some cases, did a good job.

The 96th General Hospital (NP),[11] in England, reported that the wardmen on the whole did a very excellent job but that the number of ward attendants was not sufficient for the number of patients.

In the 30th General Hospital,[12] in Belgium, the "ward personnel * * *

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[7] Additional information concerning the neuropsychiatric technicians is contained in "Medical Department, United States Army. Neuropsychiatry in World War II. Volume II. Oversea Theaters." [In preparation.]

[8] Quarterly Report, 18th Station Hospital, 1 July–30 Sept. 1944.

[9] Quarterly Report, 51st General Hospital, 1 Oct.–31 Dec. 1944.

[10] Annual Report, 116th Station Hospital, 1944.

[11] Annual Report, 96th General Hospital (NP), 1944.

[12] Annual Report, 30th General Hospital, 1945.

did very good work in the management of the ward and in the supervision of outdoor activities."

The 262d Station Hospital,[13] in the Mediterranean theater, stated that there were six wardmen with previous experience and the rest developed such experience on the neuropsychiatric section.

In Iceland, at the 92d Station Hospital,[14] with one closed and one open ward, there were nine technicians assigned but there was always a rapid turnover and very few men were trained but some had a little experience. There was "some slight inservice training here but no real course for wardmen."

In Divisions

The experiences of division psychiatrists [15] who utilized psychiatric technicians in the neuropsychiatric treatment centers located in the clearing companies of divisions were perhaps not nearly so unfavorable as has previously been described. Undoubtedly, the realistic surroundings of the combat zone and the identification with combat psychiatric casualties which could readily be established created conditions for high motivation and superior performance of the psychiatric technician. Almost invariably, the psychiatrists were given technicians who had little or no previous experience with psychiatric patients. Either they were general medical corpsmen or were selected from patients who had recovered from wounds or disease. These men, however, rapidly learned to handle psychiatric problems. They came to understand what was occurring to the trembling, apprehensive soldier who displayed a startled reaction at slight noises, or who sat and stared bemused with his traumatic combat experience, and had to be urged to speak and take part in recreational activities.

In the main, the psychiatric technicians were readily indoctrinated to assume a firm but sympathetic manner with psychiatric casualties. They became invaluable observers for the division psychiatrists in noting disturbances in eating, sleeping, and sociability, and in general behavioral abnormalities. The psychiatric technicians also became effective in "scrounging" for supplies, in arranging ingenious substitutes for showers and feeding utensils, and in providing diversionary activities. The psychiatric technicians worked closely with the division psychiatrist and learned quickly by doing and by example, to become identified with the goals of rapid and forward psychiatric treatment. They took the initiative in supervising recreational and reconditioning activities. In time, some of the psychiatric technicians were utilized as assistants in the employment of catharsis induced by barbiturates. They learned to be good listeners

[13] Annual Report, 262d Station Hospital, 1944.
[14] Annual Report, 92d Station Hospital, 1944.
[15] This section is based on information furnished by Col. Albert J. Glass, MC, USA (Ret).

as the patients related accounts of their combat experiences, permitting them to ventilate without making value judgments.

One can say in summary that the division psychiatrist faced with the problem of handling large numbers of terrified, anxious patients leaned heavily upon his enlisted aids who quickly perceived their role with the support and approval of the psychiatrist. Thus, the psychiatric technicians became indispensable members of the treatment team which sought to aid the sick soldier regain emotional composure and motivation for return to combat duty from a forward treatment site.

SUMMARY

Psychiatry was "the Cinderella of military medicine" in World War II, and the neuropsychiatric technician was one of its many "forgotten men." Again and again, it becomes evident that although the recruitment, classification, and assignment of psychiatric personnel in general was not adequately planned, there was a need for properly trained personnel. The civilian experiences of the psychiatrists and psychiatric nurses, the prewar drives for better mental care, and, no doubt, the "selfish" desire of these more experienced people to have their personal burdens of mental patient responsibilities eased prompted the almost universal attempt to train ward attendants to become more efficient neuropsychiatric technicians. There is no doubt that this succeeded to a great extent and that this success in military hospitals established a trend in civil mental hospitals after the war that materially improved this and other levels of mental care in all hospitals and institutions.

Section II. Psychology Technicians

Morton A. Seidenfeld, Ph. D.

SELECTION

Hundreds of men and women serving in the enlisted ranks were pressed into neuropsychiatric services and sections as psychology technicians (psychology assistants). They made remarkable and worthy contributions to the clinical psychology program of the Army. It is indeed unfortunate that, just as for other activities and services carried during the peak pressures of a war, almost nothing was recorded regarding these willing and able workers.

The use of enlisted psychology technicians initially appeared to have developed largely as a matter of expediency. Hospital commanders, on request, often permitted their chiefs of neuropsychiatry to make use of

selected enlisted personnel in carrying out services which were badly needed and for which experienced professionals were not available.

One of such services which was always lacking enough trained workers was, of course, clinical psychology. Like psychiatry, clinical psychology suffered markedly from an inability to procure enough trained people, and even when minimal standards were applied so as to increase the number of men available for training, the time required to prepare workers before they could be sent to the treatment installations was generally far too long to serve the demands that already existed.

It is not surprising then that harassed and overburdened psychiatrists with only one and more often no trained clinical psychologists, but with a definite feeling of need for the services which the psychologist could render, requested permission to search for the best available enlisted personnel to assume some of this responsibility, at least until qualified professionals were made available.

Let it be said at once that, although the psychology technician may have come into being as a matter of expediency, the services rendered were generally of the highest order. As a rule, these workers were selected only after a review of personnel records of the command in order to locate by military occupational specialty classification and educational records those individuals who had at least a baccalaureate degree in psychology or whose training and experiences were weighted with a preponderant amount of psychological background. Thus, those who had majored in psychology in undergraduate colleges, those who had worked in the fields of personal or educational activities, and the like were most frequently selected. Occasionally, when people with even such limited backgrounds were not available, a further compromise was made in the direction of taking the most intelligent and trainable persons for the job.

TRAINING

The training of the psychology technician on the job was, like his selection, often a matter of expediency. Generally, the psychiatric staff, including the psychiatrist, clinical psychologist, and social worker (to whatever extent they were represented at a given installation), did the training. This varied in every situation, extending from a few hours of orientation on how to give the more simple individual tests and record the observations made, to rather detailed courses running for an hour or two daily, for a period of several weeks. These more elaborate courses covered most of the important elements of clinical testing, counseling, group psychotherapy, and other matters of clinical importance.

Here again, one cannot but be impressed at the degree to which these young enlisted workers took to the training, at the interest and effort they exhibited in mastering the more formal aspects of the training, and at the alacrity they demonstrated in learning how to apply their formal training

to the practical problems presented by their patients on the wards. Not all the psychology technicians were expert on their job, but a very high percentage of them did succeed so well in what was expected of them that both psychiatrists and clinical psychologists, working with them, have repeatedly commented upon their outstanding contribution.

It is worthy of note that it was not solely the rapidity and the effective manner in which these psychology technicians applied the briefly taught psychological skills that was such a great contribution. There was an equally great if not greater value that accrued from utilizing these psychology technicians. These workers, being out of the rank and file of enlisted personnel, very often engendered confidence and removed the resistance of the patient to the authoritarian concept that many soldiers had toward the officer, be he psychologist or psychiatrist. There was an easily established empathy that often seemed to work to the advantage of all, and by the time the enlisted technician had established his rapport with the patient, he opened the way for members of the medical teams to do a more effective job.

It is of interest to repeat here that 346 enlisted men in the Army who met the proper professional and military qualifications in force at the time were directly commissioned as second lieutenants and assigned to clinical psychology. Later, the ever-present need for more clinical psychologists resulted in the appointment of WAC enlisted women to officer status in this field (p. 576).

SUMMARY

Though the psychology technician was born of necessity, the program of the future should contemplate the continued use of such enlisted personnel. If better trained and with a role more clearly defined, they can indeed be utilized to increase the extent of psychological services offered. They can also be of great value in therapeutic situations that otherwise might be less effectively met when initial contacts are threatened by the officer-enlisted man's barrier.

Section III. Psychiatric Social Work Technician

Myron J. Rockmore, M.A.

NEED FOR TECHNICIANS

The historical development of the role of psychiatric social work has been well chronicled in chapter XX.

The development of the technician category originated out of program needs at a time when the military psychiatric social worker was demon-

strating his importance to the function of psychiatric services in the military organization. It has been implied in the documentation in chapter XX that there was a lag between the operational demonstration of these services and their incorporation into Army-wide regulations. For example, at Fort Monmouth, N.J., a classification clinic was organized (p. 610) in which the function of the military psychiatric social worker was established.[16] This civilian specialization was not incorporated officially into Army administrative structure until 23 August 1943 when SSN (Specification Serial Number) 263 was established. During this interval, considerable clinical experience was amassed.

With the establishment of the Classification Clinic, the Adjutant General's Office, on 20 April 1942, requested that it furnish periodic reports of its service. A report covering the first 5 months of the work of the clinic received Army-wide distribution and a commendation from Col. Patrick S. Madigan, MC. This was before the appointment of Col. Roy D. Halloran, MC, as chief of the Neuropsychiatry Branch in the Surgeon General's Office. In a report of his inspection of the Fort Monmouth mental hygiene unit on 9 December 1942, Colonel Halloran said: "It is to be noted that the psychiatric social worker was not listed in the Adjutant General's occupational listing. Since such workers are fundamental to the functioning of this unit, the need for formal recognition of this profession was indicated and provisions made for giving some workers ratings and commissions." Colonel Halloran further reported "* * * the Unit was willing and able to train a certain number of psychiatric social workers for use elsewhere * * * that the training period should not be less than 6 weeks."

QUALIFICATIONS

This impetus stimulated the professional civilian-trained social workers in the Fort Monmouth unit to submit a "Suggested Outline and Considerations for a Training Program for Military Psychiatric Social Workers," dated 8 July 1943. It was recognized that the identification of civilian social workers by SSN 263 would include a wide variety of training and experience which would require additional orientation to the military setting before effective performance could be expected. The original specification for this enlisted classification required "a graduate degree in social work from a recognized school of social work or at least 2 years' supervised experience in social work activities in a private or public agency." In practice, personnel were identified in various installations as qualifying for the specification who could not be expected to carry the degree of responsibility expected from a professionally trained person. Nevertheless, the urgency of the need to utilize assigned persons for

[16] Freedman, H. L.: The Unique Structure and Function of the Mental-Hygiene Unit in the Army. Ment. Hyg. 27: 608–653, October 1943.

expanding functions demanded an analysis of the job content so that further delegation of partialized responsibility would make maximum use of skilled manpower.

This was dramatically illustrated when, on 20 October 1943, five psychiatric social workers were ordered to the relatively new military installation, "The Reconditioning Facility," at Thomas M. England General Hospital, Atlantic City, N.J., to assist in the development of a program for the reconditioning of neuropsychiatric casualties.[17] In the complexity of this installation, many duties and responsibilities were delineated which did not require professional training. It was further recognized that the unique conception of supervision, which is highly developed in professional social work training and civilian practice, was an adequate safeguard in allocating responsibilities to nonprofessionally trained social workers.

The conception of supervision in the social work context underscored not only the administrative responsibility of the supervisor but also highlighted his additional responsibility for the educational growth and development of the worker in his charge. Professional social work training has carefully conceived this role as the basis of its fieldwork instruction. Accordingly, it was possible through job analysis to extend the skill of the military psychiatric social worker through the assignment of "The

FIGURE 65.—Intake interview by a psychiatric social worker assistant, who had been a patient himself but upon recovery was found to have sufficient background to be reassigned to his present duties. [From the film "Shades of Glory."]

[17] Freedman, H. L.: The Mental-Hygiene-Unit Approach to Reconditioning Neuropsychiatric Casualties. Ment. Hyg. 29: 269–302, April 1945.

Technician." Numbers of military installations were staffed by one professionally trained social worker who was able under supervision to select and train technicians to render service of a high qualitative order [18] (fig. 65). This move was perhaps accelerated by the issuance, on 29 February 1944, of War Department Circular No. 90, relating to the procurement of female technicians, which undercut the graduate school requirements of SSN 263.

As the Army committed more troops to combat and as the manpower needs became more urgent, reconditioning facilities expanded. Concurrently, the need for specialized personnel, technically trained to service and administer programs, expanded. The effectiveness of the military psychiatric social work technician was recognized further as the psychiatric social worker achieved an officer classification (MOS 3605).

The effectiveness of this category of nonprofessional personnel was governed by four major variables, as follows: (1) Competent supervision by professionally trained social work personnel, (2) proper selection of the person to be trained, (3) training content and practice, and (4) assignment experience.

TRAINING

Selection

The graduate schools of social work have developed certain criteria [19] which are used in selecting candidates for admission to their programs. These criteria have also been utilized in selecting personnel in large public agencies, and the methods of selection were found to have validity.[20] The cornerstone of this selective process is the interview conducted by a trained person who has some orientation to the method his profession has developed. Through the interview method, it is possible to elicit material in a variety of areas which reflects the candidate's personality in action. Some of these are related to warmth and responsiveness, sensitivity, judgment and discrimination, and subjectivity-objectivity; psychological mindedness, that is, insight into himself and empathy with others; work capacity; and recreational and cultural interests. This personality complex of factors in a person who has the intellectual capability to conceptualize is primary in the selection of technician trainees.

Curriculum

Essential to the performance of the social work technician is successful

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[18] Greving, F. T., and Rockmore, M. J.: Psychiatric Casework as a Military Service. Ment. Hyg. 29: 435–506, July 1945.

[19] Berengarten, Sidney: Pilot Study: Criteria in Selection for Social Work. *In* Social Work as Human Relations. New York: Columbia University Press, 1949, pp. 170–195.

[20] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Interviewing for Staff Selection in Public Welfare. Children's Bureau Publication No. 355—1956. Washington: U.S. Government Printing Office, 1956.

completion of basic military training. Without this, one cannot expect acceptance of the Army's purpose and administrative structure which is so necessary to assist soldiers with problems of adjustment to the military environmental demands. Selection of the candidate should take place during this initial period and should be followed by a carefully developed inservice curriculum. The content should be geared to a specific Army mission with the emphasis of practical application of theoretical content. Subject matter should be taught both didactically and in seminar, concurrently, with supervised fieldwork. The following suggested material might be included:

1. A historic survey of neuropsychiatric services in the Army.
   a. Emphasis of military necessity of these services.
   b. Growth and development of outpatient military psychiatry.
2. Army administration and regulations pertaining to—
   a. Mental health of troops as a command function.
   b. Classification and assignment.
   c. Articles of War.
   d. Plans and training.
   e. Medical Services.
   f. Induction and separation.
   g. Others pertinent to prevention and control of military behavioral maladjustment.
3. The concept of the "Clinical Team" and its operation in a variety of military installations.
4. Neuropsychiatric problems in relation to Army adjustment emphasizing—
   a. Survey of common psychopathology.
   b. Symptomatic causes and effect in combat and noncombat areas.
   c. Analysis of dynamic factors in military life and environment and their behavioral implications (everyday psychopathology of everyday Army life!).
5. Interrelationships between psychiatric and other Army community resources:
   a. Use of military channels.
   b. Methods and purpose of interpretation (Public Relations).
6. The interview as a helping process.
7. Case seminars.
8. Fieldwork supervision.

The time allotted to the topics as well as the content may vary depending upon the academic level of the group. Fieldwork should begin by the end of the second week with the case seminars utilizing this content for integrating theory and practice. In 6 to 8 weeks, through joint evaluation of the instructional staff, there should be sufficient knowledge of the trainee to predict his capacity to continue to profit from supervision in an assignment in an installation.

ASSIGNMENT

The mission of the specific installation to which the technician is assigned will have a bearing on the extent to which his beginning skills will be used. The function of the specific psychiatric service and the availability of professionally trained and untrained personnel in relation to the demands for service will also be a factor. The quality of the supervision and the readiness to assign the technician to increasing responsibility which will tax his potential is vital. The type of personnel required for assignment must show increasing skill with experience under supervision or reassignment is indicated.

The initial technicians' assignments should be designed to familiarize them with the function of the specific psychiatric service and its relationship with the installation. This can best be done through such assignments as reception work, duty with regard to clinical records, data collection, liaison with other sections, and escort duty. This should acquaint the technicians with the flow of cases through the service and establish the relatedness of the service to other segments of the installation. It will also serve as orientation to the problems to which the service addresses itself and some of the variety of case dispositions. Simultaneously, the supervisor should be developing an individualized appreciation of his technician through observation and performance. In this fashion, the timing toward increased use of the technician for special or general interviewing can be gaged. Regularly scheduled conferences with the technician should extend his training, evaluate his progress, and show the pace at which increased responsibility or broadening duties can be assumed.

The closing of the war aborted plans for proposed training centers for military psychiatric social workers and technicians. Training centers were planned on the east and west coasts for simple deployment. The basic experience was, however, carefully noted and subsequently assimilated within the Army administrative structure. It was recognized that civilian professionally trained psychiatric social workers needed a period of training to adapt their civilian skills to the military setting and also that a course of instruction could develop a technically proficient category of personnel to assist the psychiatric social work officer in the discharge of his duties.[21]

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[21] The implementation of these principles was contained in the "Program of Instruction for Psychiatric Social Workers Course," 15 September 1947, at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.—M. J. R.

Part V

THE POSTWAR PERIOD

CHAPTER XXVI

Problems of Adjustment in Return to Civilian Life

Norman Q. Brill, M.D., and *Herbert I. Kupper, M.D.*

THE SOIL FOR POTENTIAL PROBLEMS

> Probably, the great majority of the "average" veterans, those without physical or psychological disability, met with no serious emotional problems in the course of their return to civilian status. To be sure, some, for many possible reasons, such as not finding preferred employment or a proper place in life, reacted adversely. Nevertheless, while most veterans *were not* "problems" in themselves, it would be playing ostrich not to recognize that they *had* problems, both big and little.[1]

Before entering the Army, a great many soldiers had never been away from home. Many had not matured emotionally or intellectually. Many had never before been threatened with serious danger. Many had never been required to assume real responsibility. Many had come from farms and rural communities and, for the first time, met people from all sections of the country, or for those who went overseas—from various parts of the world. They met girls different from the ones in their hometowns. Their lives were completely different. They endured hardship; they were confronted with death; they killed the enemy and saw their own buddies dying. They had read and heard of strikes and high wages and on returning home were disillusioned to see the extent to which business went on as usual—as if there were, or had been, no war. They witnessed complacency and selfishness and were convinced that people at home could never understand what they had been through.[2]

The phantasies of home which had helped them tolerate misery and suffering while in service were exploded by the less attractive realities of their homes, their families, and their girls. Some were bitter about the sacrifices they had made at a time when others, not in the service, continued to live in comfort and to prosper. Upon arriving home, they were confronted with the need to reinstate themselves in an establishment that seemed to be running well without them.

The variety of adjustments defy description.[3] There were problems

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[1] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 365.

[2] Brill, N. Q.: Veterans With Problems. J. Home Econ. 38: 325–328, June 1946.

[3] The problems that were encountered by female military personnel were not unlike those experienced by men. They were described by Solomon, P., and Winfield, M. C.: Needs and Problems of Military Women in Readjusting to Civilian Life. Am. J. Orthopsychiat. 15: 454–462, July 1945. See also chapter XV, "The Women's Army Corps."—N. Q. B., and H. I. K.

for some of relinquishing positions of authority; of readjusting to a life without excitement, where each individual action was not important; of being freed from military discipline, once again to make decisions and plans; and of assuming, again, the responsibilities of husband or father.

It was all these considerations that made many fear that the man who had been taught to kill by the Army would return to civilian life without the restraints society had, previously, so carefully built into him. Possibilities of "epidemics" of crime and violence were predicted by some who believed that the hostile aggressive forces which had been released by war could not be suddenly turned off.

In the service, new attitudes and standards toward many things were developed. Preciseness, cleanliness, and attention to detail were emphasized. Obedience and self-discipline became necessities. Anger, frustration, and rage could no longer be expressed as directly as could have been in civil life. Separation from women and living in an essentially male environment resulted in glorification of pin-up girls, in idealization of the "girl he left behind," and in rough talk and scatological jokes. One's "buddy," one's unit, the best "goddam army," the "toughest" general, and a common danger bound young men together in mutual love for and dependence upon each other for a leader or a father figure. These feelings came into direct conflict with wishes to be independent and to survive in combat, which engendered deep feelings of guilt that were so commonly uncovered in cases of "combat fatigue" where ambivalent underlying feelings could not be faced.

Immediately after the war ended, there was joy at imminent homecoming, but there followed a period of uncertainty in both soldier and civilian. Slowly, anxiety mounted about the possible emotional and psychological problems of demobilization. Families and communities became worried over how much their men had changed, and the public press with a hue and a cry began to publish "scare" articles. The word "readjustment" came into vogue, with public realization that young men had been sent into situations in which they were bound to change.

DIVERGENT VIEWS ON POTENTIAL PROBLEMS

A study by Corwin [4] revealed that 20 percent of a sampling of 100 officers and 32 percent of a sampling of 100 AAF (Army Air Forces) enlisted men, returning from overseas, had had some concern about how civilians would feel toward them. Their anxiety was provoked by rumors they had heard of conditions in the United States, by doubts about how they would be treated and regarded by their families and friends, and by the existence of illness in their families. Their concerns were, for the most part, relieved by the sympathetic and satisfying welcomes which

[4] Corwin, W.: Attitudes of Soldiers Returning From Overseas Services. Am. J. Psychiat. 102: 343–350, November 1945.

were accorded them upon their return. Corwin believed that their anticipatory anxiety was to some extent the result of the breaking of ego-strengthening relationships with their units; of an awareness of further emotional demands to be made upon them by their friends and families; and of a return to earlier conflicts, the solution to which was postponed and not solved by the war.

Chisholm,[5] in his study of the emotional problems of demobilization, stated: "Cessation of hostilities was experienced as a major emotional shock by soldiers generally * * * a very extensive loss of orientation, a feeling of being lost." He believed that soldiers might become highly labile in mood, unstable, and unpredictable—that "the sudden release from fear of death would leave them disorganized and uncertain."

Menninger[6] and Burton and his associates,[7] however, held a contrary view. They recognized the magnitude of the problems of readjustment for the individual and the community but believed the alarmist's description of the problem was exaggerated. They also believed that, all in all, only a small number of men, some discharged for neuropsychiatric reasons, would present serious adjustment problems in the civilian situation. They seemed to have confidence in the resilience of the ego or personality of these men as well as of the capacity of families, Army, and community to aid the wavering personality.

Menninger seemed to believe that the capacity of these men to adapt to soldiering and then to battle, if handled well, provided a reasonable expectation that they could readapt to civilian life. Therefore, he thought that the process of civilian adaptation might produce little if any more damage for the majority with intact egos.

ANALYSIS AND METHODS OF ATTACKING THE PROBLEMS

At any rate, the Army attempted, within its resources and capacities, to effect a satisfactory transition. A separation qualification record was made of each man.[8] This provided a summarized personnel data sheet with education, work history, aptitudes, physical condition, and positive aspects of his military record which could be used in seeking employment. Military specialties were related to civilian skills.

Counseling was offered but only 50 percent of the men accepted. Help was offered by selected officers and men specially trained to give advice about jobs, domestic details, or when necessary, to make referrals to psychiatric treatment facilities.

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[5] Chisholm, G. B.: Emotional Problems of Demobilization. *In* Military Neuropsychiatry. Baltimore: Williams & Wilkins Co., 1946, pp. 63–69.

[6] Menninger, W. C.: The Problem of the Discharged Neuropsychiatric Patient. *In* Military Neuropsychiatry. Baltimore: Williams & Wilkins Co., 1946, pp. 70–77.

[7] Burton, I. F., Eaton, M. T., Jr., and McMahan, H. G.: Incidence of Neuropsychiatric Disease in the Demobilized Veteran: Study of 10,000 Army Separatees. Am. J. Psychiat. 103: 165–171, September 1946.

[8] Bender, W. R. G.: Rehabilitation and the Returning Veteran: the Man as He Leaves the Service. Ment. Hyg. 29: 1–7, January 1945.

Chisholm [9] advised the Canadian Army to institute a number of talks to all men. He believed that talking of their anxieties, aggressions, and doubts would be helpful preparation for the future in much the same way as the men who were to participate in the North African invasion were helped before the invasion to understand the customs of a strange land and people. No such talks were broadly instituted in the U.S. Army, and there were no statistical data from which to determine whether the talks were helpful in the Canadian Army. Chisholm [10] also urged families of returning servicemen to assume their share of the responsibility for readjusting.

Cities like New York with advanced social service agencies immediately established civilian service centers to give advice and to work with Federal, State, and other city agencies. Ethel Ginsburg [11] described the Veterans Service Center in New York which was opened to give information on community resources for employment, counseling, and similar help. Braceland [12] emphasized the need for psychiatric treatment facilities, while Smith and Wood [13] urged local county medical societies and general practitioners, especially in rural communities, to assume their share of the responsibility for the treatment of veterans who developed emotional disorders in the process of readjusting to civilian life.

Campbell,[14] in a report on 434 veterans hospitalized in the Kings Park State Hospital, from August 1945 to June 1946, stated that, of these, 110 developed their illnesses after discharge from the service. The prospect of separation, he believed, buoyed up many military personnel and obscured personality disorders which might otherwise have been noted before discharge. Some patients admitted feeling "let down" as their separation approached. He believed that these men suffered severe feelings of loss when they left their Army units. He concluded that part of the reasons for these severe reactions were that the complexities of civilian life were too much for them and brought to light or aggravated latent symptoms. They had broken down after discharge and after personal maladjustments. He believed that they might have been aided by further orientation before discharge, although this, he agreed, was speculation.

It was noteworthy that studies in training camps overseas revealed that only a relatively small percentage of men asked for help with their domestic and emotional problems. This was further borne out by counseling agencies at home which found that a majority of men would not

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[9] See footnote 5, p. 723.

[10] Chisholm, G. B.: The Soldier's Return. Psychiatry 8: 103–105, February 1945.

[11] Ginsburg, E. L.: Rehabilitation and the Returning Veteran; Veteran Into Civilian: The Process of Readjustment. Ment. Hyg. 29: 7–19, January 1945.

[12] Braceland, F. J.: Psychiatry and the Returning Veteran. Ment. Hyg. 30: 33–46, January 1946.

[13] Smith, L. H., and Wood, H. C.: The General Practitioner and the Returning Veteran. J.A.M.A. 129: 190–193, 15 Sept. 1945.

[14] Campbell, J. A.: From VJ * * * Mental Disorder Following Service Discharge. Psychiatric Quart. 20: 375—380, July 1946.

take advantage of counseling for domestic problems or that they quickly left counseling as soon as immediate anxieties subsided.[15]

Kupper [16] was of the opinion that the ego of the veteran had been altered in military life and consequently "weakened" for civilian living. The tendency of men who wore a victorious uniform, and belonged to a "team," was to regard all civilians as "they." Implied was a distrust of a group of strangers and unconsciously a feeling of inadequacy when one's uniform was discarded and the "team" dispersed. Therefore, there was an increased likelihood for using primitive mechanisms of projection and displacement. Corwin [17] found that some men, while overseas, had expressed violent bitterness toward labor unions, selfishness, and lack of sacrifice on the part of civilians.

Domestic problems were often greater than the realistic situations warranted. There were some good reasons for this. A 3- or 4-year absence tended to make for concrete and baffling changes. A baby became a child. A wife who had been a girl was a woman and a mother. Friends, relatives, and one's hometown changed. However, a basic difficulty of decreased flexibility seemed to exist in the veteran himself.

The veteran's fright and dependency needs pushed the vast majority of men to join veterans' organizations which provided closeness and understanding as well as practical advice. It was noteworthy that memberships were often dropped within 3 to 5 years after the war's end.

Col. Howard A. Rusk, MC,[18] of the Convalescent Training Section, AAF, spoke in many communities to audiences of as much as 11,000 after showing them films on "Combat Fatigue" and "Out of Bed into Action" which depicted to civilians how and why their returning men might have transient violent gripes. The National Committee for Mental Hygiene, in 1944, set forth a series of rules for civilian behavior which were excellent.[19] As adjuncts in the professional field, a "National Neuropsychiatric Institute Act" was introduced and passed by Congress, for the purpose of coordinating psychiatric activities, making grants-in-aid and the like. It provided the assistance that was needed to staff such facilities as community clinics and veterans' installations.

There was some suggestion [20] that sexual readjustment in marriage was a transient problem. This was because tender loving feelings and sexual expressions during the war were so often disassociated from one another and had to be reassociated with consequent difficulties. Excep-

[15] Burling, T.: Community Organization for Meeting Problems of Psychiatrically Disabled Veterans. Am. J. Orthopsychiat. 14: 680–698, October 1944.

[16] Kupper, Herbert I.: Back to Life: The Emotional Adjustment of Our Veterans. New York: L. B. Fischer Pub. Corp., 1945.

[17] See footnote 4, p. 722.

[18] Rusk, Howard, in *New York Times*, October 1945.

[19] Rennie, Thomas A. C., and Woodward, Luther E.: When He Comes Back and If He Comes Back Nervous: With Guide to Community Resources. New York: Rehabilitation Division, Nat. Com. Ment. Hygiene, Inc., 1944.

[20] See footnote 15 above.

tions were instances where latent difficulties aggressive as well as sexual were reopened leading to more difficulties than usual.

The question of conscience or the superego was a key one. Without a stable individual set of morals, values, and ideals, the veteran tended to be prone to outbursts of irritation and to seek solace in veterans' groups where "old times" could be discussed. Although there were no statistics to prove this, all war writers, including Erich Maria Remarque,[21] eloquently and inevitably predicted this. The veterans' attitude as depicted by Remarque was: "There they stand and propose to teach us again. What can they teach us? We know life better than they. We have gained a harsh, cruel knowledge. We could teach them. If a raid were made on us, they'd all be rushing about * * *." Little wonder that parents complained of how their sons had changed and seemed to be uncertain as to values, civilian rules, morals, and the like.

THE VETERAN GOES TO SCHOOL

The slow reestablishment of a stable superego was vital just as it was for his growth at age 6 when he entered school and the outside world. A survey by the Office of Education of the Federal Security Agency indicated that about one million men and women wanted to go to school (13 May 1945, New York Times). In part, the GI bill of rights came into being because of this. Even the youngest veterans at school often felt aloof and far removed from campus activities. Colleges noted their seriousness and also the inordinate number who married. This was rather unusual since they and their children lived on so little.

The desire to return to school in such numbers did not arise just from the serious wish to study to improve oneself and was not always an evidence of an increased maturity. Too often, there were immature needs to channel sexual and aggressive urges in a combination of being married as well as of being dependent schoolboys. Initially, it seemed to help overcome feelings of instability.

ERROR IN CRIME PREDICTION

It has been repeatedly alleged that every postwar period seems to have shown an increase in violent impulses and delinquency. There are no figures that could be used to substantiate this.[22] Those men who were discipline problems in military life sometimes continued a life of crime outside the service. The insufficiency of recorded data on all such problems following demobilization is significant. The complexities of the human factor and

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[21] Remarque, Erich Maria: The Road Back. Boston: Little, Brown & Co., 1931.

[22] Dixon Wecter (When Jonny Comes Marching Home. Boston: Houghton Mifflin Co., 1944, p. 462) concluded "that a normal man is ever turned into a killer must be gravely doubted * * * in general the homicide rate after * * * wars, so far as it bears any known relation to the soldier, is far from sensational." —N. Q. B., and H. I. K.

his interaction with the mores of his society were almost impossible to judge accurately. Almost all prophets and soothsayers erred somewhat because only the broadest speculations could be made. The chief asset of all returning men seemed to be their trend toward self-readjustment, and one of the chief aids in this seemed to have been vocational placement with counseling.[23]

SOCIAL AND ECONOMIC HELP

The GI bill of rights and related laws were a bonus in advance. The U.S. Employment Service set up a nationwide job hunt to enable men to reenter a competitive society. The Veterans' Administration guaranteed $50 million worth of low-interest loans. There was special unemployment pay; about 8 million veterans took on-the-job or school training. The net result of this was that veterans overtook nonveterans their own age in earning power. All but 8 percent returned their Government loans. Only one in eight joined the American Legion versus one in three of the World War I veterans. Most fused their talents and opportunities so well that they provided a major national asset.

In retrospect, one can see that the social and economic planning helped enormously with many problems which previous postwar epochs led everyone to expect. There certainly must have been many personal problems which were brought about by dislocation and readjustment. But by enlightened Government aid, the majority of such problems were overcome by the opportunities and help that were proffered.

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[23] (1) Rosenzweig, S.: Emotional Implications of Military Rejection and Discharge. Psychiatric Quart. (Suppl.) 19: 11–19, 1945. (2) "Time" magazine, in its 5 January 1959 issue, published a revealing article entitled "Whatever Happened to the Veterans." They observed that many ominous prophecies came to naught because of the comeback the Nation provided.—N. Q. B., and H. I. K.

CHAPTER XXVII

The Psychiatric Patient After Discharge

Norman Q. Brill, M.D., and *Herbert I. Kupper, M.D.*

MISCONCEPTIONS ABOUT PSYCHONEUROSIS

Nearly every patient discharged from an Army hospital with a psychiatric diagnosis was himself greatly concerned about the possibility that his relatives or friends might be afraid of his behavior or look upon him as a "crazy man or as a failure." [1] The term "psychoneurosis" had received a great deal of publicity during the war, and unfortunately, there was widespread misunderstanding of what it meant. Many people confused it with psychosis. Great fear had been expressed by many over the Army's returning all these psychoneurotic patients to civilian life. The use of the word "cracked-up" had implied that some irreparable damage had been done and gave the impression that the brain had been affected. Concern was expressed that the psychoneurotics would create a serious problem in the community, that they would go about and behave in a peculiar fashion, that there would be strange expressions in their eyes, and that there would be manifestations which the average person associated with insanity.

Stigma of a psychiatric diagnosis.—By 1 August 1942, Illinois for example, had 2,354 veterans of World War II.[2] Of this number, 1,014, or 40 percent, had been discharged from the service because of psychiatric and personality defects. Of this psychiatric group, 101 were in State institutions for the mentally ill. Most of the remainder (86.7 per cent) were employed and generally making a fair adjustment. Those who had received administrative discharges as "inapt" or because of "undesirable habits or traits of character," and whose discharge certificates contained such phraseology, encountered some difficulty in obtaining employment. Men discharged for psychoneuroses during the war also encountered some hesitancy on the part of employers to hire them.[3]

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[1] Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948, p. 21.

[2] Sommer, C. S., and Weinberg, J.: Discharged Veterans of World War II in State Hospitals and in the Community. Arch. Neurol. & Psychiat. 50: 105–107, July 1943.

[3] Brill, N. Q., Tate, M. C., and Menninger, W. C.: Enlisted Men With Overseas Service Discharged From the Army Because of Psychoneuroses; A Follow-up Study. Ment. Hyg. 29: 677–692, October 1945.

POSTDISCHARGE ADJUSTMENT DURING THE WAR

Later in the war, with the large number of men being discharged medically, for psychiatric reasons, there was great interest within the Army to know more about how these men were faring in civilian life. The Neuropsychiatry Consultants Division, SGO (Surgeon General's Office), undertook a followup study, in 1944, of enlisted men discharged from the Army for psychoneuroses before 1 January 1944.[4]

Questionnaires were sent to a random sample of 5,937 and replies were received from 4,178 (over 70 percent). From the replies, 85.9 percent of the men were employed in contrast to 93.7 percent who had been employed before induction. In general, these men considered their health to have been adversely affected by their Army service, but thought of this impairment chiefly in terms of physical rather than emotional illness. Of the entire group, 14.5 percent were hospitalized at least once after leaving the Army, but in many instances, the hospitalization was by the Veterans' Administration for purposes of evaluation rather than for definitive treatment. Burling [5] commented on the emphasis the Veterans' Administration gave to settlement of claims rather than to real rehabilitation. As early as 1942, Pratt [6] had predicted the danger of this type of approach.

Pratt [7] was able to obtain reports on 55 percent of 256 soldiers who had been discharged in 1943 with a diagnosis of psychoneurosis. He found that 90 percent were employed within an average of 5 to 6 weeks after discharge. Of the 256 men, 22 percent maintained that they encountered some difficulty in securing work because of the nature of their discharge. From an unpublished study of 500 patients who had been discharged from the Fort Story Convalescent Hospital, Va., 85 percent were found to be gainfully employed, 8.5 percent were attending school, and only 6.5 percent were unemployed. A British study gave essentially these same findings.[8]

Qualitative changes in health and adjustment, however, were found in such men by several Canadian investigators.[9] In the study conducted by the Neuropsychiatry Consultants Division, this was found to be more so with men who had had oversea service, and this finding was confirmed

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[4] Brill, N. Q., Tate, M. C., and Menninger, W. C.: Enlisted Men Discharged From the Army Because of Psychoneuroses; A Follow-up Study. J.A.M.A. 128: 633–637, 30 June 1945.

[5] Burling, T.: Community Organization for Meeting Problems of Psychiatrically Disabled Veterans. Am. J. Orthopsychiat. 14: 680–698, October 1944.

[6] Pratt, G. K.: The Call of the Cradle, Some Psychiatric Problems of Demobilization. Ment. Hyg. 26: 39–49, January 1942.

[7] Pratt, D.: Reemployment of the Psychoneurotic Ex-Soldier. Psychiatry 8: 3–8, February 1945.

[8] Lewis, A.: Social Effects of Neurosis. Lancet 1: 167–170, 6 Feb. 1943.

[9] (1) Griffin, J. D., and Henderson, M. F.: A Study on the Post-Discharge Adjustment of Psychoneurotic Soldiers. National Research Council of Canada. [Report C–6071 filed with Proceedings of the Fourth Meeting of the Associate Committee on Army Medical Research, 27 May 1944.] (2) Griffin, J. D., Henderson, M. F., and Ross, W. D.: A Study on the Post-Discharge Adjustment of Psychoneurotic Soldiers. National Research Council of Canada. [Report C–6111 filed with Proceedings of the Fifth Meeting of the Associate Committee on Army Medical Research, 10–11 Nov. 1944.]

by a postwar followup study of war neuroses, supported by the Veterans' Administration.[10]

RESIDUALS OF WARTIME PSYCHIATRIC ILLNESS

A study of enlisted men, ages 18 to 25, who had been hospitalized during 1944 for psychoneuroses was undertaken in 1948 by Brill and Beebe for the Committee on Veterans Problems of the National Research Council, in cooperation with the Veterans' Administration, the Army, and the Navy, to determine the condition of these men approximately 5 to 6 years after they had been treated in the service. Of a total of 1,475 men,[11] 27 percent were found to have no psychiatric illness, 33 percent had mild psychoneurotic disorders, 25 percent had moderate or severe psychoneurotic disorders, 11 percent were diagnosed personality or behavior disorders, and 1.5 percent were suffering from schizophrenic reactions.

Only 10 percent were free of symptoms. The most common symptoms, affecting at least 40 percent of the men, were irritability, anxiety, gastrointestinal complaints, restlessness, and headache. Phobias, obsessions and compulsions, hypochondriacal reactions, psychotic symptoms and behavioral disorders, difficulty in concentrating, and depression were also reported,[12] but less frequently.

It was interesting that, in 24 percent of the men, all their symptoms at followup had originated before entering the service. In 43 percent, the symptoms were reported to have originated in the service. After 5 years, most of the men still felt that their health was not as good as it had been when they entered the service; yet, as a group, they had, in the main, continued to improve since separation from the service. Nearly a third of the group still looked upon their difficulty as "organic." [13] The great majority exhibited adequate ability to handle their jobs without excessive interpersonal difficulties, without frequent changes or irregularity of employment, or without resorting to work below their level of competence. The structure of civilian occupations and job situations is enormously more varied than the military and it does not follow that these men would necessarily have been as well adjusted in military occupations.

Of the total group, 76 percent of the men were employed full time, 9 percent part time, and 15 percent not at all. Illness was a factor in preventing full employment for 14 percent, or just over one-half of those

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[10] Brill, Norman Q., and Beebe, Gilbert W.: A Follow-Up Study of War Neuroses. VA Medical Monograph Series. Washington: U.S. Government Printing Office, 1955.

[11] By June 1953, of the 1,475, 36 had died. This compares with a normal expectation of 31 deaths in this size and age group. Of the deaths, six were suicides in comparison with an expectation of two. In 1950–51, four men were in prison, none of them for any major crime of violence.—N. Q. B., and H. I. K.

[12] It is difficult to estimate what proportion of a cross section of the civilian population would report specific symptoms if questioned in the same way as were the men in this study.—N. Q. B., and H. I. K.

[13] This phenomenon was reported by many others; for example, Owens, R. H.: The Neuropsychiatric Dischargee. Ment. Hyg. 29: 666–676, October 1945; and Burling, T.: Community Organization for Meeting Problems of Psychiatrically Disabled Veterans. Am. J. Orthopsychiat. 14: 680–698. October 1944.—N. Q. B., and H. I. K.

not employed full time. A large number had married since separation, and most of these men had adjusted satisfactorily to married life. Adjustment was least often satisfactory in the area of the community where socially acceptable behavior and conformity to the mores were involved. Here, 19 percent of the men showed impaired adjustment and another 25 percent a questionable adjustment. In some instances, this maladjustment was also clearly present before service.

Less than 30 percent of the entire followup sample appeared to be more than slightly disabled at followup and only 8.1 percent more than moderately disabled. Only 2.1 percent had received intensive psychotherapy since discharge, 11 percent had had brief psychotherapy, and 64 percent had had no medical treatment of any kind.

A total of 915 men, 47 percent, were receiving disability compensation from the Veterans' Administration (as of 1950–51), as follows:

Monthly payment:	*Percent*	Monthly payment:	*Percent*
None	52.9	$80 to $89	.8
$1 to $9	.1	$90 to $99	.9
$10 to $19	22.3	$130 to $139	.1
$20 to $29	2.6	$140 to $149	.1
$30 to $39	1.3	$150 to $159	.1
$40 to $49	11.9	$180 to $189	.1
$50 to $59	2.4	Amount unknown	1.3
$60 to $69	2.8		
$70 to $79	.3	Total	100.0

It should be emphasized that the men in the group studies had been hospitalized for psychoneuroses, not discharged for psychoneuroses. Only 44 percent of Army cases were by CDD (certificate for disability discharge).

Since there were approximately 700,000 strictly psychiatric admissions from 1942 to 1945, it can be estimated that in 1950–51 approximately 325,000 of these men from World War II were receiving "pensions" from the Veterans' Administration. As of 30 June 1947, there were 286,000 patients who had had psychiatric illnesses in World War II who were receiving pensions from the Veterans' Administration.[14] In only a small fraction was the compensation believed (by the examiners) to have an adverse effect on the veteran's illness.

Of great interest was the fact that 21 percent of those who reported that their health was the same or better than when entering the service were receiving compensation. It is a sad fact that one-half of the men who were receiving disability compensation had never had any treatment for their emotional difficulties after discharge from the service.[15]

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[14] Menninger, *op. cit.*, p. 380.

[15] One investigator (Ginsburg, S. W.: Rehabilitation and the Returning Veteran; Community Responsibility for Neuropsychiatric Discharges. Ment. Hyg. 29: 20–31, January 1945) found 82 percent of a representative sample of men discharged from the service for psychiatric reasons were in need of some form of psychiatric assistance. However, only 25 percent could be expected to admit their need and seek help. Of these, only a small fraction were receiving psychiatric help, and the same was true for vocational help. —N. Q. B., and H. I. K.

Of the men who were hospitalized for psychoneuroses in the Zone of Interior, one-fourth were receiving compensation, lending some substance to the claim that the mere fact of hospitalization in wartime carries with it some likelihood of being granted a "pension" by the Veterans' Administration.[16] Those who broke down in or after combat—or merely while overseas—were much more apt to receive compensation. However, men who had clear-cut neuroses or personality disorders before entering the service and who were hospitalized in the service were compensated at least as often as those who had no preexistent psychiatric difficulty and whose illness in service was presumably more related to the stress of service.

POSTDISCHARGE PSYCHIATRIC ILLNESS

A special group of men who unfortunately could not be included in this study were those who developed emotional disorders after discharge from the service.[17] This was not a large group but its existence is further proof that those who were hospitalized constituted only a part of the psychiatric problems engendered or uncovered by war.

Burton and his associates [18] found, for example, that 2.57 percent of 10,000 men processed through a separation center had sufficient complaints to warrant a psychiatric diagnosis and that 0.5 percent had some degree of incapacity. Schneck [19] expressed the opinion that a large number of soldiers being demobilized could profit from help. The many readjustments which had to be effected and the whole problem of social reintegration of the discharged soldier was comprehensively reviewed by Menninger.[20] He exploded the prediction made by so many that the veteran would constitute a serious problem to society by acting out, in a life of crime, the hostility that had been engendered during the war.

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[16] Receiving a medical discharge for a psychoneurosis carried with it almost a four times better chance of receiving compensation than being returned to duty and demobilized or discharged for the convenience of the Government. Of those who were CDD'd, 57 percent received compensation in contrast to 15 percent who were discharged with disorders of similar type and severity but who left the Army from a duty status. —N. Q. B., and H. I. K.

[17] Campbell, J. A.: From VJ * * * Mental Disorder Following Service Discharge. Psychiat. Quart. 20: 375–380, July 1946.

[18] Burton, I. F., Eaton, M. T., Jr., and McMahan, H. G.: Incidence of Neuropsychiatric Disease in the Demobilized Veteran; Study of 10,000 Army Separatees. Am. J. Psychiat. 103: 165–171, September 1946.

[19] Schneck, J. M.: Neuropsychiatry at a Separation Center. Mil. Surgeon 100: 232–233, March 1947.

[20] Menninger, *op. cit.*, pp. 363–392.

CHAPTER XXVIII

Lessons Learned

Colonel Albert J. Glass, MC, USA (Ret.)

A frequent comment by frustrated and harassed psychiatrists during World War II was that responsible authorities failed to heed the lessons learned by psychiatry in World War I. Indeed, this subject is a recurrent theme in many chapters of this history. It should be conceded, however, that there has been little agreement as to what specific psychiatric lessons were learned during World War I. Also, only meager documentary evidence was available to support this or that policy, procedure, or technique as proved by experiences in World War I. Perhaps the relatively brief participation of the U.S. Army in World War I did not permit the accumulation of sufficient data to warrant conclusive statements. Regardless of reasons, the uncertainty of what was learned by psychiatry in World War I has prompted the inclusion of this final summary chapter on the major lessons of psychiatry learned in World War II.

Almost 20 years have elapsed since the end of World War II (at the time of this writing, 1965). During this period, the Korean War was fought to a stalemate (25 June 1950–27 July 1953). There have been many "brink-of-war" crises, involving the mobilization or commitment of U.S. Army Forces in Germany, Formosa, Lebanon, Greece, Vietnam, Laos, Thailand, Cuba, and other areas in some of which intermittent, small-scale combat activities have occurred. Even during relatively quiet times, the Army, also the Navy and the Air Force, has never returned to the small peacetime force that existed before World War II.

In addition, there have been marked increases in firepower by the elaboration of new and more efficient weapons and their delivery systems. The World War II Selective Service System or the "draft," [1] which was reinstituted during the Korean War, has been continued. In effect, since World War II the armed Forces have been maintained in a more or less wartime posture. These circumstances have provided an opportunity not only to utilize the lessons of World War II psychiatry but also to evaluate

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[1] Dr. Bernard D. Karpinos, Special Assistant for Manpower Studies, Medical Statistics Agency, Office of The Surgeon General, Department of the Army, furnished the following additional information: "The World War II Selective Training and Service Act of 1940 which was permitted to expire in 1947 was reinstituted in 1948 as the Selective Service Act of 1948. (Only for a period of somewhat over one year was there no such legislation.) The 1948 act was reenacted in 1950 as the Extension Act of 1950 and established, in 1951, as the Universal Military Training and Service Act of 1951. This act has been regularly reenacted since 1951 in terms of 4-year intervals, extending, as of 1963, until 1 July 1967. *See* Supplement to Health of the Army, Office of The Surgeon General, U.S. Army, May 1964, vol. 19, p. 1."

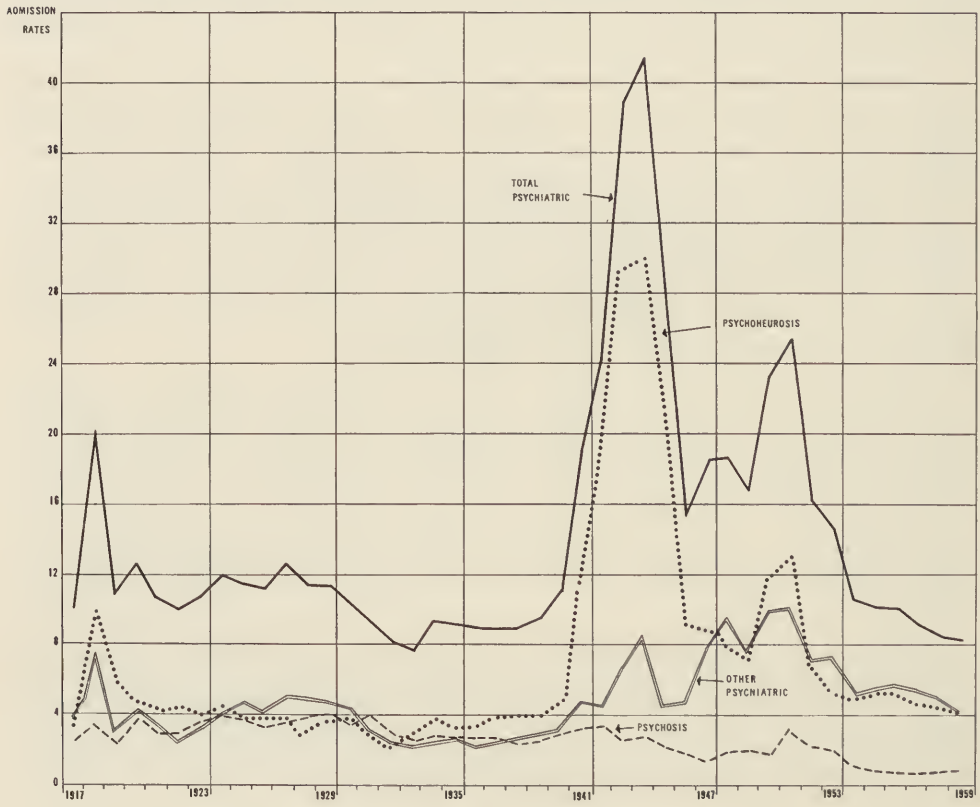
their validity in the light of subsequent experiences in both hot and cold war periods.

MAGNITUDE OF PSYCHIATRIC DISORDERS IN MODERN WARFARE

Undoubtedly, the most important lesson learned by psychiatry in World War II was the failure of responsible military authorities, during mobilization and early phases of hostilities, to appreciate the inevitability of large-scale psychiatric disorders under conditions of modern warfare. The high admission rates for psychiatric conditions in World War I, in World War II, and in the Korean War are clearly reflected in chart 15 and table 66.[2]

CHART 15.—*Admission rates for psychiatric conditions, by broad diagnostic categories and year, 1917–59*

[Rate expressed as number of admissions per annum per 1,000 average strength]



[2] Unless otherwise indicated, the statistical data in this chapter were furnished by Dr. Karpinos (see footnote 1, p. 375). By supplying this statistical report, with pertinent explanation, Dr. Karpinos made a valuable contribution to this volume, which is gratefully acknowledged with sincere thanks.—A. J. G.

TABLE 66.—*Admission rates for psychiatric conditions by broad diagnostic categories and year 1917–59*[1]

[Rate expressed as number of admissions per annum per 1,000 average strength]

Year	Diagnostic categories					
	Total	Psychosis	Psychoneurosis	Other psychiatric conditions		
				Total	Mental deficiency	Character and behavior disorders and other
1917	9.9	2.7	3.4	3.8	2.4	1.4
1918	20.4	3.3	9.9	7.2	4.1	3.1
1919	11.3	2.6	5.9	2.8	1.2	1.6
1920	12.8	3.7	5.0	4.1	1.9	2.2
1921	10.6	3.1	4.1	3.4	1.5	1.9
1922	10.0	3.2	4.3	2.5	.8	1.7
1923	11.1	3.7	4.0	3.4	1.3	2.1
1924	12.0	3.8	4.2	4.0	1.4	2.6
1925	11.8	3.7	3.7	4.4	1.6	2.8
1926	11.5	3.5	3.8	4.2	1.5	2.7
1927	12.4	3.6	3.7	5.1	2.1	3.0
1928	11.7	3.7	3.2	4.8	2.2	2.6
1929	11.6	4.0	2.9	4.7	1.9	2.8
1930	10.4	3.6	2.8	4.0	1.3	2.7
1931	9.5	3.9	2.5	3.1	.7	2.4
1932	8.2	3.1	2.4	2.7	.4	2.3
1933	7.8	2.6	3.1	2.1	.4	1.7
1934	9.5	2.9	3.9	2.7	.5	2.2
1935	9.3	2.9	3.2	3.2	.6	2.6
1936	9.2	2.8	3.4	3.0	.6	2.4
1937	9.2	2.8	3.7	2.7	.4	2.3
1938	9.2	2.5	3.7	3.0	.3	2.7
1939	9.6	2.6	3.7	3.3	.3	3.0
1940	11.2	3.1	4.7	3.4	.5	2.9
1941	19.6	3.4	11.7	4.5	1.2	3.3
1942	24.6	3.5	16.7	4.4	1.3	3.1
1943	38.1	2.6	29.0	6.5	2.1	4.4
1944	40.7	2.8	29.7	8.2	3.6	4.6
1945	28.2	2.2	21.6	4.4	.4	4.0
1946	15.7	1.9	9.3	4.5	.3	4.2
1947	18.3	1.5	9.0	7.8	.3	7.5
1948	18.4	1.9	7.8	8.7	.2	8.5
1949	16.6	1.9	7.0	7.7	.1	7.6
1950	23.6	1.8	11.9	9.9	.2	9.7
1951	25.1	2.8	12.3	10.0	.3	9.7
1952	16.0	3.1	6.9	7.0	.3	6.7
1953	14.6	2.0	5.5	7.1	.2	6.9
1954	10.6	1.6	4.0	5.0	.1	4.9
1955	10.2	1.5	3.6	5.1	.1	5.0
1956	10.0	1.3	3.5	5.2	.1	5.1
1957	9.2	1.2	3.1	4.9	.0	4.9
1958	8.5	1.3	3.0	4.2	.0	4.2
1959	8.1	1.3	2.8	4.0	.0	4.0

(*See following page for footnote.*)

Even during peacetime periods, admission rates for psychiatric disorders vary directly with the proportion of new accessions to the service. Repeated observations have confirmed that approximately 50 percent of psychiatric problems become manifest within the first year of service and about 75 percent, within 3 years. Since during mobilization and war, with a rapid expansion of military forces, most personnel are new to the service, high admission rates for psychiatric disorders are inevitable. In addition, there must be added the psychiatric casualties due to the uncertainties and fears unique to wartime stress, including separation from families and familiar supports, oversea privations, and hazards of combat. In combat alone, a ratio of one psychiatric casualty for every four battle casualties has prevailed regularly since World War I. Despite the foregoing data, which were available before and at the onset of World War II, awareness of and preparation for this potential major loss of military manpower were singularly lacking.

It is highly probable that in future wars there will be a similar neglect, inasmuch as psychiatric disorders are an unpopular and vexing phenomenon. Moreover, the issue of emotional disorders is too readily obscured or confused by moral condemnation and widespread use of such terms as "misfits," "cowards," and "slackers," all of which make it easy to ignore the problem, particularly when there are so many pressing wartime logistic, training, and personnel requirements. However, as was the futility of King Knut (King of England and Denmark, 1017–1035 A.D.) in ordering the tides to roll back, the high tides of psychiatric casualties in war, which are also a product of natural forces, cannot be ignored, rationalized, or ordered into submission. It was this basic failure to recognize the magnitude of psychiatric problems in war which was responsible for a later series of errors in preparation and planning.

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[1] Fundamental changes occurred during this period with respect to both classification and nomenclature of psychiatric diagnosis. During 1917–29, psychiatric conditions were listed under "Nervous System, Diseases" and "Mental Alienation" (including alcoholic psychosis). Alcoholism without psychosis (without differentiating between acute and chronic) and drug addiction were listed under "General Diseases." During 1930–37, "Alcoholism with Psychosis" was transferred to "General Diseases," and listed alongside with the combined chronic and acute alcoholism (without psychosis). In 1937, "Paresis" was transferred and listed under "Infective and Parasitic Diseases." Since 1938, alcoholism without psychosis has been reported separately as acute or chronic. However, inasmuch as no separate classification of alcoholism by acute and chronic was available before 1938, this particular diagnosis was excluded, for consistency, from this table. (Alcoholism without psychosis was included, however, in table 67 and chart 16, inasmuch as disability discharges for alcoholism undoubtedly refer to chronic alcoholism, currently classified as a psychiatric condition.)

The diagnostic categories, as given in this table and in chart 15, include the following specific diagnoses:

Psychosis: General paresis, dementia praecox, manic depressive psychosis, alcoholism with psychosis, and other psychoses.

Psychoneurosis: Hysteria, psychasthenia, psychoneurosis, neurasthenia, neurocirculatory asthenia, and neurosis.

Other Psychiatric Conditions: Mental deficiency, character behavior disorders and other. The category "character and behavior disorders and other" includes constitutional psychopathic states, drug addiction, enuresis, and malingering (appendix A, tables 2 and 8). "Shell shock" reported for 1918 and 1919 (a rate of 1.51 for 1918, and 0.11 for 1919, per 1,000 mean strength per year), was included under "Psychoneurosis."

NOTE.—The entry .0 indicates a rate of less than .05.

ORGANIZATION OF PSYCHIATRY FOR WAR

Failure to appreciate the magnitude of the psychiatric problem had its logical consequence in a delay in providing organizational leadership in the Surgeon General's Office. Thus, it was not until February 1942 that a small and mainly ineffective Neuropsychiatry Branch was established in that office. This branch was gradually enlarged and improved in function until finally, on 1 January 1944, some 2 years after the onset of hostilities, neuropsychiatry was elevated to the status of a representative division in the Surgeon General's Office and given sufficient staff to perform its mission adequately (ch. II).

During the crucial mobilization and early war periods, however, the lack of planning, preparation, and direction resulted in inadequate or faulty psychiatric policies and practices, wastage of psychiatric personnel, and consequent huge losses of military manpower. From these mistakes, only partial correction was later possible. It was mainly through the trial-and-error efforts of rank-and-file psychiatrists that effective methods of dealing with wartime psychiatric disorders were discovered or relearned. From these experiences were gradually evolved operational concepts and practical methods of management and treatment which were organized and welded into a comprehensive and effective program, during the later phases of World War II, by the emerging psychiatric leadership in the Surgeon General's Office.

The World War II experience clearly indicates the necessity for psychiatric leadership at the highest level of military medicine. The nucleus of such leadership must exist as an integral component of the Surgeon General's Office during peacetime so as to be capable of rapid expansion in war. In essence, the Army Medical Service must be similarly concerned with preparation for the management of psychiatric casualties as for the more traditional problems of injury and disease. It should always be remembered that modern war produces two unique types of casualties in large numbers; namely, injuries and psychiatric disorders, both of which are caused by traumatic forces set forth by a changing and hostile environment. It is highly desirable that career military psychiatrists be developed and maintained so that they may comprise a nucleus of psychiatric leadership in the Office of The Surgeon General during peacetime and, thus, be immediately available during any mobilization or planning for war.

As World War II demonstrated, civilian psychiatrists can adapt and utilize their skills for the psychiatric problems of war, but time is required for such transition and orientation to the special problems of military psychiatry. Moreover, if newly placed in the position of leadership in the Office of The Surgeon General, civilian psychiatrists, even if of superior caliber, must have time to develop the necessary contacts with other military agencies, to understand the language, attitudes, and channels of com-

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munication of the military organization, and to learn ways and means of making needed changes to existing doctrine and programs.

It is difficult, if not impossible, for civilian psychiatric groups, such as the American Psychiatric Association, to maintain adequate interest and preparedness for military psychiatry. Preparedness for war is the responsibility of the regular Military Establishment and cannot be delegated to civilian organizations, no matter how well intentioned or motivated such groups may be.

The wisdom of psychiatric leadership by career military psychiatrists was illustrated during the Korean War. Col. John M. Caldwell, MC, Chief Psychiatric Consultant, in the Office of The Surgeon General, from 1946 to 1952, was in a position, during that conflict, to take prompt and vigorous action to implement rapidly an effective wartime psychiatric program.

To summarize: Military psychiatric leadership in the Office of The Surgeon General must be operational during peacetime and should not be discarded for reasons of expediency or economy. During war, this nucleus of career military psychiatrists can be rapidly augmented by experienced senior civilian psychiatrists. After a period of transition, the Regular Army military psychiatrists in the Office of The Surgeon General, if desired or needed, can be transferred to other assignments.

PSYCHIATRIC SCREENING

Perhaps the most widely known lesson of psychiatry in World War II was the inability of psychiatric screening to identify effectively and thus eliminate the military psychiatric problem at induction. Despite the fact that approximately 1,600,000 registrants were classified as IV–F (unfit for military service) in World War II because of mental disease and mental or educational deficiency (appendix A, table 5), indicating a disqualification rate about 7.6 times as high as in World War I (appendix A, table 7), separations for psychiatric disorders in World War II were 2.4 times as high as in World War I (appendix A, table 10).

Ginzberg and his associates,[3] in evaluating the disqualifications for military service in World War II, pointed out the shortcomings of World War II psychiatric screening. One cannot quarrel with their evaluations or be surprised by their conclusions. Even during World War II, many psychiatrists engaged in induction screening were highly dubious of its effectiveness. Indeed, soon after the war, many publications by wartime psychiatrists appeared,[4] attesting to the inefficiency of the psychiatric

[3] Ginzberg, Eli, Anderson, James K., Ginsburg, Sol W., and Herma, John L.: The Ineffective Soldier: The Lost Divisions. New York: Columbia University Press, 1959, p. 36.

[4] (1) Menninger, William C.: Psychiatry in a Troubled World: Yesterday's War and Today's Challenge. New York: The Macmillan Co., 1948. (2) Bloomberg, W.: Plan for Screening, Induction, and Utilization of Manpower. Am. J. Psychiat. 105: 462–465, December 1948. (3) Egan, J. R., Jackson, L., and Eanes, R. H.: Study of Neuropsychiatric Rejectees. J.A.M.A. 145: 466–469, 17 Feb. 1951. (4) Eanes, R. H.: Standards Used by Selective Service and a Follow-Up on Neuropsychiatric Rejectees in World War II. *In* The Selection of Military Manpower. (A symposium edited by Leonard Carmichael and Leonard C. Mead.)

screening procedure. In fact, so well demonstrated was the unreliability of individual psychiatric screening that the routine examination of inductees by psychiatrists was abandoned by the Army soon after the end of World War II and was not even reinstituted during the Korean War.[5]

In retrospect, there can be no doubt that psychiatric screening as performed during World War II was an impractical and ineffective procedure. However, it is more important from the standpoint of learning from the lessons of history to appreciate the circumstances and reasons which led to the vigorous employment of, and the unrealistic reliance upon, this instrument so that perhaps the same error may not be repeated in future wars.

Rationale for Psychiatric Screening

First, it should be recognized that belief in the efficacy and necessity of psychiatric screening had existed since World War I. Repeated references to this effect by senior medical officers appear in the annual reports of The Surgeon General, between World War I and World War II, in which the occurrence of psychiatric disorders in the peacetime Army was largely blamed upon the unsatisfactory examination of applicants for enlistment and, thus, failure to heed the lessons of World War I. Interestingly enough, there was no insistence that such examinations need be performed by psychiatrists. The detection of overt or potential mental disorders was considered quite within the capability of any mature and conscientious medical examiner with previous military experience. These year after year exhortations by senior medical officers had seemingly no effect in lowering the frequency of psychiatric disorders. Yet, belief in psychiatric screening continued. It seemed as if the examiners, during those years, were exceedingly perverse individuals who, despite being told repeatedly of their derelictions, persisted in being lax or incompetent.

Apparently, with time and a mounting need due to the heightened prospects of war, belief in screening grew into a firm conviction. Considered thus, in the mobilization period and the early phases of World War II, psychiatric screening was seized upon as the major solution to the mental health problems of modern war and advocated by a host of lay and medical leaders, both military and civilian, including a number of prominent psychiatrists.[6] It must be stated, however, that many psychiatrists

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National Academy of Sciences, National Research Council, Washington, D.C., 1951, pp. 149–156. (5) Fry, C. C.: A Study of the Rejection Causes, Success and Subsequent Performance of Special Groups. *In* The Selection of Military Manpower, *op. cit.*, 1951, pp. 133–138. (6) Brill, N. Q., and Beebe, G. W.: Some Applications of Follow-Up Study to Psychiatric Standards for Mobilization. Am. J. Psychiat. 109: 401–410, December 1952. (7) Glass, A. J., Ryan, F. J., Lubin, A., Ramana, C. V., and Tucker, A. C.: I and II. Psychiatric Prediction and Military Effectiveness. U.S. Armed Forces M.J. 7: 1427–1443, October 1956; 1575–1588, November 1956. (8) Glass, A. J., *et al.:* III. Factors Influencing Psychiatrists. U.S. Armed Forces M.J. 8: 346–357, March 1957.

[5] Karpinos, Bernard D.: Qualification of American Youths for Military Service. Medical Statistics Division, Office of The Surgeon General, Department of the Army, 1962, pp. 7–9.

[6] Glass, Albert J.: Psychosomatic Medicine. *In* Medical Department, United States Army. Internal Medicine in World War II. Volume III. Infectious Diseases and General Medicine. [In preparation.]

expressed doubt, advised caution, or argued against any sweeping reliance upon screening procedures (ch. VIII).

Curiously enough, when the psychiatric history of World War I is examined, little evidence is found to support the effectiveness of psychiatric screening. Yet the experiences of World War I were repeatedly referred to as proof of its validity. It is true that "Neuropsychiatry," volume X of the history of the Medical Department in World War I, contains statements favorable to psychiatric screening and strongly recommends its employment. But screening at induction or before acceptance for military service, by psychiatrists, was infrequently practiced in World War I (appendix A). Moreover, volume X furnished no information, such as followup studies, which document the effectiveness of psychiatric screening, except for the empirical impression that preembarkation screening reduced the incidence of psychiatric disorders in the American Expeditionary Forces.

As noted in chapter I, one gains the strong impression that local board medical examiners in World War I rejected only obvious neuropsychiatric disorders of which the majority were mental deficiency and epilepsy. In contrast, psychiatrists of World War II endeavored, as instructed, to identify and reject the potential as well as the relatively fewer overt neuropsychiatric problems before service. It was this effort to eliminate potential mental disorders which was responsible for the much higher rate of psychiatric rejections in World War II over that of World War I.

Indeed, the major technical lesson to be learned from the psychiatric screening experiences of World War II lies in appreciating the serious and perhaps insurmountable limitations inherent in any single cross section individual type of psychiatric or psychological examination which, before induction, attempts to render reliable judgment of future effectiveness or mental breakdown. Clearly, psychiatric prediction or any medical effort to forecast future disability is much more accurate when signs and symptoms of abnormality or disease are already present, as apparently was the case in most psychiatric "rejections" in World War I, than are attempts to predetermine the behavior of individuals, particularly when the later circumstances of assignment, associates, leadership, hardships, hazards, and other environmental variables are unknown.

More difficult to explain is why so many psychiatric authorities in World War II apparently assumed that, by interview examination alone, the later effectiveness of future soldiers could be reliably estimated, particularly when there existed no established criteria or demonstrated validity for such a predictive procedure. In this connection, there was prevalent then, as now, a widely held belief in the indestructibility or the invariable persistence of psychiatric symptomatology. Thus, it is believed that emotional or behavioral disorders, as seen at the time of clinical manifestations when usually a history of previous difficulties or pathological

background is readily obtained, would have displayed similar symptoms, findings, and history at some prior occasion even if under entirely different circumstances and that this could have been identified, if only examined properly. This myth persists despite the day-to-day experiences of psychiatrists in the changeability of history, symptoms, and behavior even in severe mental illness, such as schizophrenia, let alone neurotic or deviant behavior syndromes.

It was this belief which accounted for repeated complaints before World War II of the improper examination of recruits. Rarely was there recognized that motivation, interview behavior, or history could be radically different at induction from that obtained under conditions of mental breakdown or maladjustment when the individual concerned must explain to himself, and others, reasons for failure. The individual motivated to enter the service views the present and past in a favorable light, which represents truth for him at this time. Conversely, the unmotivated draftee can readily consider the apprehensions of the present and the conflicts of the past as "being nervous all my life" and cite numerous examples of his unsuitability for service. The more thorough and experienced the examiner, the more evidence of neurotic tendencies or, at least, personality abnormality can be uncovered. Such was the case in World War II when sophisticated psychiatric examiners rejected a high number of inductees, but their increased efficiency in ridding the service of potential breakdowns was never proved. In fact, there is some indication that the reverse could be true (ch. VIII).

Second, and again in retrospect, reliance upon psychiatric screening can be understood as a logical extension of the denial or the failure to appreciate the magnitude of the psychiatric problem in war. In effect, the mass employment of psychiatric screening can be equated with the use of a magical device that would do away with the problem. To support this conclusion, it must be admitted that a reasonably thorough screening examination, as envisioned and advocated by psychiatrists, was accomplished in only a minority of inductees. In fact, it can be categorically stated that psychiatric screening in World War II did not receive a fair opportunity to demonstrate its effectiveness, for the following reasons:

1. In most instances, psychiatrists were permitted only 2–5 minutes or less to conduct a screening examination, usually without collateral information. This indifference in providing sufficient time for such a difficult task perhaps best illustrates the denial of the psychiatric problem in World War II by reliance upon a token process. Moreover, when psychiatrists were not available, as happened not infrequently, other physicians were designated to serve as induction station psychiatrists and, having been so named, were assumed to possess the same capability as trained and experienced psychiatrists.

Thus, as a result of the difficulties mentioned in providing sufficient time and trained personnel, more often than not psychiatric screening be-

came a farce and the commonly used several-question examination a well-known target of World War II jest and humor.

2. As stated by Ginzberg and his associates, in "Lost Divisions," psychiatric criteria for induction varied considerably during World War II, depending upon War Department policies relative to the utilization of so-called marginal manpower. During the mobilization period before hostilities, an army of 1 million was the objective. Under these circumstances, psychiatrists were enjoined to reject all potential risks, as a superior group was desired to be trained as officers and noncommissioned officers and to serve as the cadre for a much larger army in the event of war. Unfortunately, with the outbreak of war, the same policy was continued.

In later 1943, when it became evident that manpower was not unlimited, this liberal rejection policy was reversed, and psychiatrists were instructed to accept any individual who had the capability for performing even limited military service. Thus, it was that the rejections for psychiatric reasons more often reflected War Department desires and needs relative to quality and quantity of manpower rather than the presence of a mental disorder or a potential mental disorder as found by the psychiatrist.

Post-World War II Psychiatric Screening

Finally, what has been the fate of psychiatric screening in the postwar years? As stated previously, the routine psychiatric examination for military service was discarded soon after World War II. Instead, only those draftees and applicants for enlistment are referred for psychiatric consultation who present, at the Armed Forces examination stations, definite symptoms or documentation of a mental disorder. With this change in the processing procedures, existing during the Korean War (July 1950 through July 1953), about 2 percent of youths examined for military service were disqualified for service because of psychiatric abnormalities. The overall qualification and disqualification rates for that war period were as follows:[7]

	Percent
Qualified:[1]	
Physical Category A	58.9
Physical Category B	11.5
Physical Category C	6.0
Total	76.4
Disqualified:[1]	
Administrative reasons	2.6

[1] These data were derived by taking into account the entire manpower pool; namely, those who were examined by the Armed Forces examining stations for induction or enlistment, as well as those who fulfilled their military liability as a member of a Reserve unit (for example, National Guard, Reserve Officers' Training Corps, and other Reserve units). Disqualifications by the local boards for moral reasons or for manifestly disqualifying medical defects were included in these computations.

[7] Karpinos, B. D.: Fitness of American Youth for Military Service. Milbank Mem. Fund Quart. 38: 214–247, July 1960.

Failed mental test only	7.9
Failed mental test and medically disqualified	1.8
Medical reasons only [2]	11.3
Total	23.6
Grand total	100.0

[2] Includes 0.5 percent for neurologic, 1.9 percent for psychiatric, and 8.9 percent for "other medical reasons," respectively.

Parallel with the liberalized policy in regard to psychiatric screening, a more comprehensive mental testing was introduced after World War II. In 1950, the AFQT (Armed Forces Qualification Test) was instituted, designed to evaluate the examinees' "potential trainability." [8] This test produced higher disqualification rates than the corresponding tests in World War II. It is of interest, therefore, to compare the rejection rates of World War II with those of the Korean War, as affected by these changes.

The disqualification rates for World War II, by broad disqualifying causes, were as follows:

	Percent rejected [1] of total examined
Medical:	
Neurologic	1.7
Mental disease	5.5
Mental or educational deficiency	4.3
Other medical	18.2
Total	29.7
Nonmedical (administrative)	0.5
Grand total	30.2

[1] Derived from the "Distribution of Registrants 18–37 Years of Age in Class IV–F and Classes With "F" Designation by Major Disqualifying Cause, as of August 1945, World War II," as reported by the Selective Service Headquarters. (See appendix A, tables 5–7, for the detailed sources and manner of calculation.) These rates differ somewhat from those published by Ginzberg, *et al.*, *op. cit.*, table 8, p. 36.

The disqualification rate for the Korean War was reported as 23.6 percent (above)—a rate lower than the 29.7 in World War II. It must be recognized, however, that the examinees of the Korean War were much younger than those of World War II.[9] Because of these age differentials, the highest difference in the disqualification rates of World War II and the Korean War was, as expected, for "other medical reasons."

Disqualifications for psychiatric disorders were clearly lower during the Korean War than in World War II (1.8 percent versus 5.5 percent)

[8] *See* Karpinos, "Qualification of American Youths for Military Service," *op. cit.*, pp. 10–12, for a discussion on the development of this test; its functions; its content areas; manner of scoring; and mental grouping.

[9] For an approximately comparable age group, however, the World War II data show about the same rejection rate. As shown in appendix A, table 6, the rejection rate for the 18–25 age group was 22.7 in World War II.

because of the new orientation toward eliminating at the examination stations only "gross psychiatric conditions." Relatively more were disqualified, however, on the more comprehensive mental test (AFQT) : 7.9 percent failed the AFQT only (p. 745) versus 4.3 percent disqualified for mental or educational deficiency in World War II (p. 745). The combined disqualification rate for mental unfitness (psychiatric disorders and mental test failures) were the same; namely, 9.8 percent in both World War II and the Korean War.

Although it is true that the two wars are not comparable, the fact that the Korean War shows considerably lower admission rates for psychiatric disorders than World War II (chart 15 and table 66) does not support the contention in regard to the efficacy of the psychiatric screening or the necessity of such routine screening.

As a result of World War II experience, there has been an increasing trend toward the utilization of the objective type of test for determining "potential trainability," not only for selection but also for assignment purposes. The AFQT fulfills such an objective, as it classifies the examinees on the basis of their scores on the test in five mental groups. Those who fall in the lowest mental group are disqualified; those who qualify (above mental group V) are classified in four groups, indicating progressive gradation of "trainability," for mental group IV to mental group I.

Similarly, other criteria can be utilized to separate individuals into groups which give reasonably predictable duty performance. For example, high school graduates, as a group, function significantly better in military service (95 percent) than those with only part high school attainment (90 percent) ; they, in turn, are more effective than grammar school graduates (80 percent).[10]

By means of such group criteria, selection for service can be rapidly and economically accomplished in accordance with the size of armed forces required and the available manpower resources. For example, if only a moderate sized army is desired, as was the case in 1940, induction standards can be adjusted so as to accept only superior and average groups. In times of war, general mobilization, and a relative shortage of manpower, criteria for acceptance can be lowered to include below average and even marginal groups.[11]

GAIN IN ILLNESS

Adverse Effects of Hospitalization

An almost universal experience of medical officers in World War II concerned the deleterious effect of hospitalization. In a significant number

[10] See footnote 4 (7), p. 741.

[11] In fact, the Army does not accept now (1965) applicants for enlistment below mental group III. It excludes not only the low mental group V but also IV. This was made possible because this complete evaluation by mental group is done at the time of examination, not after the examinees have entered the military service, as was done in World War II on the basis of the Army General Classification Test. *See* Supplement to Health of the Army, *op. cit.*, p. 23.—A. J. G.

of military personnel, hospitalization seemed to fixate symptoms, retard expected clinical improvement, and negatively influence motivation for return to duty. For these mainly ambulatory patients, it seemed evident that remaining in a sheltered hospital status, even with the restrictions of illness, represented a considerable advantage over the stress and strain of active duty. Such gain in illness or the obtaining of tangible benefits from symptoms of disability was quite well known before World War II, particularly by psychiatrists and by practitioners of industrial medicine. From the standpoint of sheer numbers, however, gain in illness in World War II was a ubiquitous phenomenon. It was a daily vexing problem for medical officers assigned to hospitals, as well as to officers serving with troops and in dispensaries, who were confronted with the persisting complaints of soldiers endeavoring to enter medical channels.

In retrospect, the large-scale occurrence of gain in illness should not have been so surprising. The phenomenon was well known in World War I and a familiar problem of military medicine between the wars. In World War II, circumstances were particularly favorable for the elaboration of gain in illness. Literally millions of men were uprooted from their homes and familiar supports and subjected to regimentation, deprivations, and hazards.

Inability to adjust or adapt to the military wartime environment led to mounting tension which not infrequently resulted in deviant or apathetic behavior. More commonly, however, a variety of ill-defined psychologically induced or associated clinical disorders was produced that included (1) overt psychiatric symptoms, usually of the neurotic type; (2) persistent somatic complaints mainly in the gastrointestinal, cardiovascular, and musculoskeletal spheres, with negative findings of "organic" disease; (3) peptic ulcer, hypertension, allergic disorders, dermatological conditions, migraine, and other so-called psychosomatic diseases; and (4) unexplainable residual syndromes from major and minor injury, surgery, heat exhaustion, diseases such as pneumonia, meningitis, and rheumatic fever, and even spinal puncture.[12]

As previously stated, there was little planning, preparation, or even recognition that such maladjustment disorders would occur in large numbers and constitute a major military medical problem. The newly commissioned medical officers soon appreciated that many of these psychological syndromes were "functional" in nature. However, there was no organized program for their evaluation, management, or treatment. Also, at this time, individuals with persistent complaints, claiming an inability to perform duty, could only be managed by hospitalization for diagnosis and treatment. Thus, the stage was set for the mass hospitalization of such symptomatic disorders, with its inevitable complication of gain in illness. The more thoroughly symptoms were investigated, the longer the hospitalization; and the greater the gain in illness, the more convinced became

[12] See footnote 6, p. 741.

patients that they had valid medical, and thus honorable, reasons for relief from duty and even discharge from the service. In the newly constructed cantonment hospitals of the time, it was common to see hundreds of these ambulatory patients, sitting and lying about on the wards or roaming the corridors and recreation areas. Under these conditions, an atmosphere was created that was highly suggestive of gain in illness to patients convalescing from so-called organic disease and injury, as well as stimulating to others, out of the hospital, to seek relief from adjustment difficulties through medical channels. One observer of the time, Eisendorfer,[13] commented: "Neurosis is as contagious as a virulent infection. For every neurotic patient hospitalized there are 10 more with potential neuroses who do not require much stimulation to react in a similar manner."

Dilemma of the Medical Officer

Many frustrated medical officers unable to cope with the persistent complaints of these patients, despite their best efforts of diagnosis and treatment, explained resistance to improvement as being due to neurotic predisposition or functional overlay. Others, perhaps the majority, viewed gain in illness as a conscious evasion of duty and used such terms as "goldbricking," "malingering," and "misfits." Almost all medical officers endeavored to refer or to transfer such patients to the psychiatrist. This is illustrated by Eisendorfer's report that, in the first 6 months of 1943, of all patients admitted to Tilton General Hospital, N.J., 48 percent were examined by the neuropsychiatric service for consultation, treatment, or disposition. But psychiatric wards were also congested, and there was a chronic shortage of psychiatric personnel. Psychiatrists were especially reluctant to accept for transfer patients who had extensive hospitalization because of prolonged clinical investigation or residual symptoms from disease or injury. Such patients were overtly hostile toward any effort to remove their favorable hospitalized status. Thus, no one wanted these patients who in turn resented their physicians. An impasse was created for which medical discharge seemed to be the only solution. Medical separation was not only the easy way out for both patient and medical officer but was also recommended by official directives and prominent lay and military medical authorities, on the grounds that "there is no place in the Army for the physical and mental weakling." [14]

Prevention of Hospitalization

During these early years, it became apparent to many wartime psychiatrists and other medical officers that hospitalization in itself created or

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[13] Eisendorfer, A.: Clinical Significance of Extramural Psychiatry in the War. Medicine 5: 146–149, March 1944.

[14] Circular Letter No. 19, Office of The Surgeon General, U.S. Army, 12 Mar. 1941.

perpetuated illness and disability. An obvious solution was the prevention of hospitalization for the purely symptomatic disorders and maladjustment problems. Thus, in 1942, psychiatrists spontaneously moved toward the extramural management of neurotic-type disorders, which concept and practice was expanded to become the consultation service system, to be discussed later in this chapter.

Nonpsychiatric medical officers, however, also took steps to circumvent gain in illness and the deleterious effects of hospitalization. Internists and surgeons and other specialists established outpatient treatment for many conditions from pilonidal sinus and acute gonorrheal urethritis to gastrointestinal disorders and foot strain.[15] In addition, beginning in 1942, programs on reconditioning were initiated in Army hospitals, which eventually grew into an organized effort directed by The Surgeon General, with the establishment of the convalescent hospital system. In reconditioning programs, patients were required to participate in increasing physical and mental activities until fit for duty.

Postwar Impact

For psychiatrists, it is of interest to note that continued hospitalization, with its adverse effects noted particularly with psychiatric patients in World War II, has produced a similar deleterious effect in the mentally ill patients in civilian institutions, who have been hospitalized for prolonged periods.

In the postwar years, along with the general trend in civil life toward outpatient management, whenever feasible, and the decreasing length of hospitalization with early ambulation, there has been a corresponding decline in hospitalization of military personnel. There remains, however, a constant problem of gain in illness from individuals with adjustment difficulties. Psychiatric consultation services have steadily improved and usually are called upon to aid in management and treatment before hospitalization.

In any future general mobilization, gain in illness is almost certain to become again a major wartime medical problem. In this event, it is hoped that the experiences of World War II will be considered as a guide for implementation, for there was eventually evolved an adequate program for the management and control of gain in illness.

CONSULTATION SERVICES

As a consequence of the need to prevent the adverse effects of hospitalization, beginning in early 1942, there were developed, at training camps, outpatient psychiatric facilities termed "Consultation Services." Initially, consultation services provided mainly a screening and advisory

[15] See footnote 6, p. 741.

function for line commanders in the elimination of noneffective trainees and the reclassification of those being trained in a skill beyond their capacities. Later, as psychiatric personnel for the first time functioned in a setting where soldiers lived and worked, they became increasingly aware that failure in training was not merely the inevitable result of defective or abnormal personality, but rather that faulty motivation and leadership, physiological strain, psychological stress, and situational pressures played a major role in evoking neurotic and maladjustment disorders.

Methodology

In time and with experience, psychiatrists and other personnel of the consultation services became more involved in activities designed to alter or influence attitudes and situational circumstances so as either to prevent emotional disorders or to provide for their early recognition and prompt management. To accomplish these objectives, psychiatric personnel learned to leave the office setting and become firsthand observers of training activities, consulting directly with commanders on referral problems. This approach also permitted relevant collateral and followup information to be gathered by visits to company areas. More important, such a decentralized or field operation brought about adequate communication and working relationships between consultation services and using agencies. Psychiatric personnel became familiar with the language and values of trainees and with the vicissitudes of training. Gradually, most psychiatrists in the consultation services became identified with the needs of the military service rather than with only the needs of the individual. In turn, line commanders came to know psychiatrists as exponents of reality rather than as persons with impractical theories.

In an effort to prevent disabling maladjustment, consultation services developed programs of lectures, aimed at the indoctrination of officers and other trainer personnel, on measures to maintain the mental health of trainees and the early recognition of emotional disability. Similarly, orientation talks were evolved for groups of newly inducted soldiers to promote better understanding and, thus, desensitization of the common emotional problems encountered in the transition from civil to military life. No convincing evidence was ever submitted to indicate that such indoctrination or orientation lectures reduced the incidence of maladjustment disorders in trainees. However, attitudes of both trainers and trainees became more accepting and supportive of anxiety, depression, frustration, nostalgia, and other emotional discomforts which commonly occur among trainees. Also, unusual or persistent symptoms or behavioral abnormalities were more readily recognized by trainer personnel as a signal for early referral to the consultation service. It is likely that the lecture programs were more effective in secondary prevention (early recognition

and treatment) than in the primary or actual prevention of psychiatric disorders.

Summary

Consultation services in World War II demonstrated the validity of aiding the trainee while he still struggled to cope with situational difficulties. This approach proved far superior to the previous practice of hospitalization and thus removal of the individual from the area of conflict which confirmed and fixated the failure of adaptation to military service. The efforts of consultation services markedly reduced the frequency of hospitalization for trainees and was a *major lesson* learned by psychiatry in World War II.

This lesson was not forgotten. During the Korean War, consultation services, renamed "Mental Hygiene Consultation Services," were established at all training centers and played a prominent role in the effective psychiatric program during this period. Since the Korean War, Mental Hygiene Consultation Services have been continued on all major posts in the Zone of Interior and in all oversea divisional garrisons. Mental Hygiene Consultation Services provide consultation and treatment services not only for trainees but also for all military personnel and many civilian dependents. In effect, the mental hygiene consultation service of an army post serves the military community for primary and secondary psychiatric prevention in the same manner as a mental health service provides care to a civilian community.

DIAGNOSIS AND DISPOSITION

Faulty Nomenclature

Another important lesson learned in World War II was the influence of psychiatric diagnosis in determining the disposition of marginal military personnel. As previously indicated, with the rapid expansion of the Army, there occurred increasing numbers of persistent maladjustment and neurotic-type disorders which exhibited "gain in illness" and were apparently resistant to treatment. From the beginning, psychiatrists were uncertain as to the appropriate diagnosis for these emotional reactions which were clearly related to, or precipitated by, situational events and frequently complicated by poor motivation for military service.

At this time, however, there was no generally acceptable diagnostic term, other than "psychoneurosis," to categorize situationally induced psychological syndromes, although "simple adult maladjustment," "gastric neurosis," or similar terminology was used by some psychiatrists. As stated in chapter IX (p. 229), "psychiatric nomenclature which was barely adequate for civilian psychiatry was totally inadequate for military psychiatry." In the years following World War I, psychoneurosis had come more

and more into common usage for almost all neurotic-type disorders. It is a curious commentary that the diagnostic term "psychoneurosis," developed by Freudian psychology to indicate a relatively fixed neurotic illness due to internalized unconscious conflict from faulty childhood psychosexual development, in time, was generalized to encompass a wide variety of situationally induced emotional reactions.

If the issue of psychiatric diagnosis was only of academic interest, the ubiquitous use of psychoneurosis would have been of little importance. However, as described in other chapters of this volume (IX, X, and XI), Army policy during the mobilization and early war years was to eliminate personnel of limited effectiveness, particularly psychiatric disorders. Especially emphasized was the careful detection and elimination of unstable persons and mental "misfits."

Under these circumstances, considerable pressure was exerted upon Army hospitals and their psychiatrists to admit and dispose of these problem soldiers. The Surgeon General had directed that disposition need not be delayed until a highly accurate diagnosis was established by prolonged and detailed study. "If an individual is obviously unfit, the psychiatrist should make the best tentative diagnosis and proceed promptly with the necessary action to dispose of the patient." [16]

Medical Versus Administrative Discharge

The psychiatrist, faced with increasing numbers of patients whose symptoms were quickly fixed by hospitalization and the chronic shortage of professional and ancillary assistants, could only implement the policy of disposition. Diagnosis, however, was of paramount importance. On the one hand, psychoneurosis was classified as an illness for which an honorable discharge could be readily accomplished under medical auspices by CDD (certificate of disability for discharge). On the other, a diagnosis of an inadequate or other personality disorder which was not considered an illness would result in the return of the patient to duty for possible administrative discharge because of inadaptability or undesirable habits and traits of character (section VIII, AR 615–360). Such "Section Eight" discharges could be white (honorable) or blue (without honor) with the onus of social disapproval as well as the denial of certain veteran's benefits. As described in chapter IX, the relatively new unit commanders were reluctant to initiate "Section Eight" proceedings which were not only unfamiliar, cumbersome, and time consuming, but also reflected presumed lack of leadership and command ability. Also, administrative separations required appearance before a line officer board which was often disinclined to approve such a harsh discharge for unhappy, anxious soldiers who complained of somatic or psychological symptoms and insisted that they were sick.

[16] Circular Letter No. 99, Office of The Surgeon General, U.S. Army, 4 Sept. 1942.

TABLE 67.—*Disability discharge rates for psychiatric conditions, by broad diagnostic categories and year, 1917–59* [1]

[Rate expressed as number of discharges per annum per 1,000 average strength]

Year	Diagnostic categories					
	Total	Psychosis	Psycho-neurosis	Other psychiatric conditions		
				Total	Mental deficiency	Character and behavior disorders and other
1917	3.79	1.07	0.49	2.23	1.53	0.70
1918	8.90	1.86	2.05	4.99	3.28	1.71
1919	7.20	3.20	1.61	2.39	1.34	1.05
1920	10.04	4.53	1.71	3.80	1.77	2.03
1921	6.34	2.84	1.00	2.50	1.28	1.22
1922	4.51	2.37	.80	1.34	.48	.86
1923	5.41	2.87	.74	1.80	.73	1.07
1924	6.19	3.24	.81	2.14	.85	1.29
1925	6.32	3.03	.73	2.56	.84	1.72
1926	6.11	2.89	.83	2.39	.98	1.41
1927	7.11	3.02	.91	3.18	1.30	1.88
1928	6.82	3.19	.67	2.96	1.43	1.53
1929	7.00	3.42	.67	2.91	1.26	1.65
1930	5.72	2.80	.59	2.33	.82	1.51
1931	5.46	2.90	.71	1.85	.40	1.45
1932	3.99	2.38	.54	1.07	.18	.89
1933	4.11	2.32	.89	.90	.15	.75
1934	4.74	1.97	1.49	1.28	.29	.99
1935	4.87	2.27	1.15	1.45	.20	1.25
1936	4.60	2.11	1.08	1.41	.24	1.17
1937	4.38	2.16	1.10	1.12	.14	.98
1938	3.01	1.82	1.02	.17	.05	.12
1939	2.75	1.75	.89	.11	.04	.07
1940	3.26	1.98	1.08	.20	.09	.11
1941	5.22	2.03	3.00	.19	.07	.12
1942	6.87	2.16	4.37	.34	.22	.12
1943	18.00	2.30	15.36	.34	.18	.16
1944	11.25	2.47	8.57	.21	.06	.15
1945	13.89	2.68	11.07	.14	.03	.11
1946	6.85	2.96	3.76	.13	.01	.12
1947	3.55	1.80	1.63	.12	.02	.10
1948	3.41	1.60	1.62	.19	.00	.19
1949	3.07	1.44	1.46	.17	.00	.17
1950	3.22	1.83	1.18	.21	.02	.19
1951	6.51	2.93	3.35	.23	.03	.20
1952	3.83	2.21	1.54	.08	.01	.07
1953	3.05	2.06	.96	.03	.00	.03
1954	2.32	1.68	.63	.01	.00	.01
1955	1.95	1.45	.48	.02	.00	.02
1956	1.36	1.08	.26	.02	.00	.02
1957	1.21	.95	.24	.02	.00	.02
1958	1.09	.88	.19	.02	.00	.02
1959	1.08	.88	.16	.04	.00	.04

(*See following page for footnote.*)

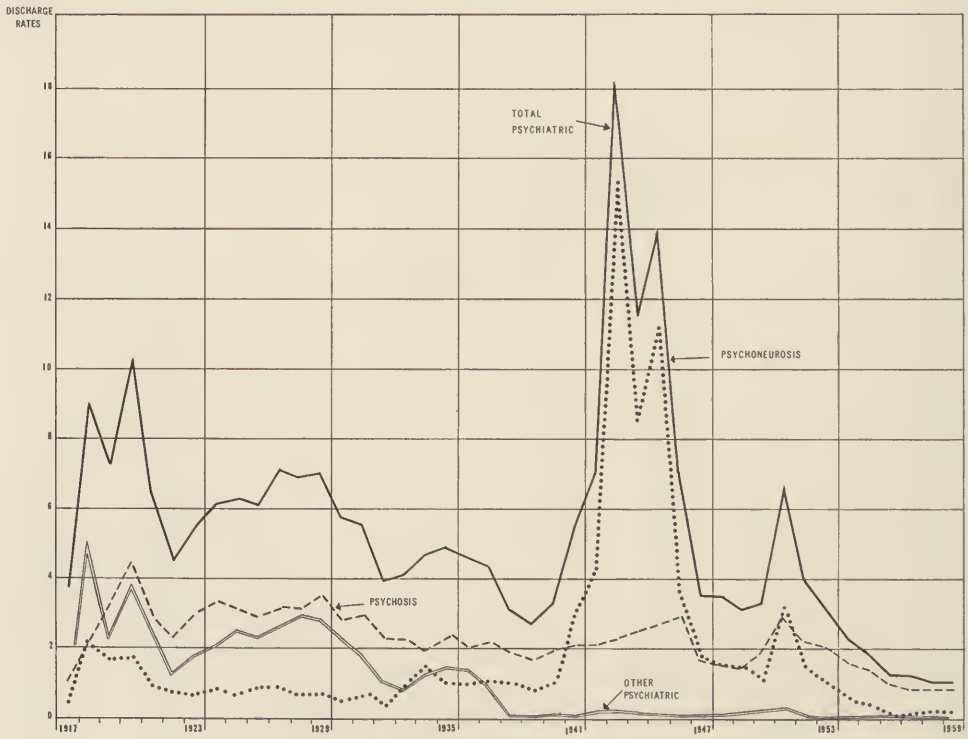
In truth, it was difficult for the psychiatrist to distinguish between personality disorders with situationally induced tension and somatic symptoms from so-called psychoneurosis. Thus, it is understandable that under these conditions, generally, the diagnosis of psychoneurosis and the disposition by medical discharge became the preferred solution. It satisfied the patient and the unit commander; it was consistent with current psychiatric nomenclature and was apparently approved by higher authority. As a result, there occurred a steadily mounting CDD rate for psychiatric disease, mainly psychoneurosis (chart 16 and table 67).

Further Problems

With the high rates of medical separations threatening to decimate the Army, concern reached the highest military authorities. On 11

CHART 16.—*Disability discharge rates for psychiatric conditions, by broad diagnostic categories and year, 1917–59*

[Rate expressed as number of discharges per annum per 1,000 average strength]



[1] See footnote to table 66. From 1949 and on, the data are preliminary and subject to modification. Since 1950 separations for disability are accomplished under the provisions of Title IV of the Career Compensation Act of 1949

NOTE.—The entry .00 indicates a rate of less than .005.

November 1943, the War Department reversed the previous liberal discharge policy and established a policy of salvage and maximum utilization of marginal personnel. A prompt effect of this directive was a precipitous decline of the medical discharge rate. As the months passed, maladjusted, inadequate, and other marginal-type personnel reaccumulated. Liberalization of medical and administrative discharges was alternately reestablished and rescinded, but to no avail—the assignment and disposition of these problem soldiers continued to plague military authorities, both line and medical, until the war ended. Basic to this issue for the lessons of military psychiatry was the utilization of the simple procedure of medical discharge, mainly for psychoneurosis as a solution for marginal personnel and logistic problems, including even shortages of hospital beds. The emerging psychiatric leadership at the Surgeon General's Office, under Brig. Gen. William C. Menninger, MC, had repeatedly opposed, with little success, the indiscriminate use of medical discharges and had consistently advocated treatment for neuropsychiatric disorders rather than merely a program of disposition.

Despite these protests, psychiatrists were increasingly criticized for the excessive use and abuse of "psychoneurosis." These criticisms came from both line and medical authorities and also from the Army Chief of Staff, Gen. George C. Marshall (ch. VII, pp. 131–133). Previously, the ineffectiveness of psychiatric screening, which had been instituted and strongly supported by higher authority, was blamed upon psychiatric examiners for being either "overenthusiastic" or "overcautious." Thus, it seemed that psychiatrists in World War II were fated to receive the brunt of blame for the failure of faulty manpower policies which had been established by their line and medical superiors. It must be admitted, however, that many psychiatrists, new to military service, too easily yielded to the pressure of line and other medical officers and attempted, through medical (psychiatric) auspices, the impossible task of ridding a large wartime Army of its inevitable maladjusted, poorly motivated, and otherwise marginal personnel problems.

In September 1944, the Inspector General began an extensive investigation which confirmed that "a majority of these cases are not NP conditions because medical officers wish to make patients of them, but because the line officers have been unable to make soldiers out of them. * * * a large proportion of medical discharges for 'psychoneurosis' have been brought about because of difficulty experienced by line officers in effecting the administrative discharges of inadequates and of persons inadaptable to the service." (See chapter VI, pp. 103–108.) The Inspector General, however, also reported that the term "psychoneurosis" had been abused and recommended that the diagnosis of psychoneurosis not be used for the inadequate and militarily inadaptable and for psychiatric conditions which were doubtful, mild, or borderline and for those whose prognosis was favorable for return to duty. Further, the Inspector General advocated a working

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diagnosis of combat fatigue or operational fatigue for psychiatric casualties arising out of combat or other hazardous duties.

The Surgeon General, in apparently accepting the viewpoint of his embattled Neuropsychiatry Consultants Division, defended the diagnosis of "psychoneurosis" and opposed any change in its usage as recommended by the Inspector General. After a series of conferences, however, a compromise was reached in which the generic term "psychoneurosis" would be omitted from the individual clinical records and replaced by the appropriate subtype of psychoneurosis, such as anxiety reaction or conversion reactions, which would serve as the working diagnosis. This change was incorporated in WD (War Department) Circular No. 81, issued on 13 March 1945.

Final Change in Psychiatric Nomenclature

The final change in military psychiatric nomenclature took place shortly after World War II, with the publication of WD Technical Medical Bulletin (TB MED) 203, issued on 19 October 1945. This quite thorough revision was accomplished by General Menninger after obtaining the opinions and recommendations of many military and civilian psychiatrists. The basic changes of the revised nomenclature consisted of two new diagnostic categories, as follows:

(1) Transient personality reactions—included all emotional reactions to acute and special stress. Cases where symptoms continued after removal of stress were diagnosed as the appropriate subtype of the psychoneurotic disorders. Transient personality reactions were divided into—

(a) Combat exhaustion, for the acute psychiatric casualties of combat.

(b) Acute situational maladjustments, for emotional disorders resulting from unusual or overwhelming stress under noncombat conditions.

(2) Immaturity reactions—included neurotic-type reactions to routine military stress, manifested by helpless or inadequate responses, passive obstructionism or aggressive outbursts.

The new diagnostic categories made unnecessary the widespread usage of the term "psychoneurosis" for situationally induced psychiatric disorders. As a result, the incidence of psychoneurosis declined sharply and remained at low levels even during the Korean War (chart 15).

The new psychiatric nomenclature proved to be not only a major advance in military psychiatry and thus an important lesson learned in World War II, but also came to represent a significant contribution to civilian psychiatry. The essential features of TB MED 203 were accepted by the Veterans' Administration and later were incorporated in a comprehensive revision of the official psychiatric classification of the American Psychiatric Association.

Final Change in Medical Discharge

The final chapter on medical discharge was written in 1949, with the enactment of new retirement laws in which enlisted personnel were medi-

cally discharged by the same procedures as for officers. Since retirement for disability was a complex process which involved review and approval by an agency of the Department of the Army, there occurred a marked decrease of medical separations for all causes, including psychiatric disorders. As a result, the medical discharge rate for all psychiatric reasons has continued to decline, even during the Korean War (chart 16). Thus, a solution was found for the excessive medical discharge of "psychoneurotic" cases, which consisted of both a *change of psychiatric nomenclature* and a *tightening of the medical discharge process.* The benefits of this hard-won lesson learned in World War II were continued during the Korean War and have become a permanent part of the policies and procedures of military psychiatry in the U.S. Armed Forces.

THE MAKING OF WARTIME MILITARY PSYCHIATRISTS

The marked shortage of psychiatrists in World War II has been the subject of much comment in several chapters of this volume. Attempts to overcome this shortage were only partially successful, but from the experiences of these efforts was derived an enduring lesson of military psychiatry.

As stated in chapter IV, "Education and Training," the heightened need for military psychiatrists during the war and their relative scarcity, thus making them unavailable from civilian sources, made apparent even in the early phases of World War II the necessity of training, or in some way utilizing, general medical officers for psychiatric assignments.

Initially, and for some time, many of the newly inducted physicians who had even a minimum of training or experience with mental disorders were placed in psychiatric positions. More often, however, others without such a psychiatric background, and, usually, with their consent, were simply assigned for duty in psychiatric sections of hospitals to fill existing vacancies. In some instances, a trained psychiatrist, usually the chief of the psychiatric section, was available to provide excellent on-the-job supervision. More frequently, the psychiatrists "by order" had little of any professional guidance and were forced to train themselves through "do it yourself" experiences of handling mental disorders, supplemented by readings from the literature and by occasional professional stimulation and teaching during the visits of psychiatric consultants from corps and army areas and from the Surgeon General's Office.

Surprisingly good results were obtained by this haphazard effort to increase the number of Army psychiatrists. In time, the vast majority of these medical officer "OJT's" (on-the-job trainees) became effective, practical military psychiatrists. Medical officers who were fortunate enough to be stationed with well-trained teachers of psychiatry received the equivalent of postgraduate psychiatric residency training during their period of military service. The bulk of OJT's, however, with little or no supervision

also progressed in psychiatric skill and effectiveness. Obviously, individual differences in talent, motivation, and interest in psychological matters played a major role in the end product that was evolved.

Probably better known than the on-the-job psychiatric training were the 12-week formal courses in neuropsychiatry which were mainly conducted at the School of Military Neuropsychiatry then at Mason General Hospital, Brentwood, Long Island, N.Y. This training was specifically designed for medical officers with no previous psychiatric experience. A total of 811 students were graduated from courses given from 15 April 1944 to 22 December 1945. From all accounts, these "90-day wonders" in psychiatry also became capable military psychiatric practitioners and, as stated by Menninger, "this training program was regarded as one of the most important and successful achievements during the war" (ch. IV).

Perhaps a major factor in the rapid acquisition and utilization of psychiatric knowledge by both the OJT's and the graduates of the formal training program was the opportunity to observe readily the obvious relationships that existed between situational stress, including variations in morale, leadership, and group identification, and the production of psychiatric symptoms and apparent disability. Here were seemingly clear-cut cause and effect correlations in which the favorable results of treatment, whether the techniques of psychotherapy or reassigment and other types of environmental manipulations, could usually be noted.

The major lesson learned from these experiences was that effective wartime military psychiatrists could be obtained by on-the-job training, preferably with adequate supervision and by relatively brief formal training courses. An added bonus effect was that many, if not the majority, of both OJT's and school graduates sought formal psychiatric residency training and thereby increased the number of needed psychiatrists in civil life.

This lesson of World War II military psychiatry was also not forgotten. During the Korean War, a formal training program in neuropsychiatry, of 16 weeks' duration, was reestablished at the Medical Field Service School, Fort Sam Houston, Tex. As in World War II, graduates of this program also rendered creditable service as military psychiatrists. Again, the majority of these officers continued after military service to complete their training and become psychiatrists in civilian life.[17]

Since the Korean War, the small numbers of additional psychiatrists needed by the Army to fill existing vacancies have been obtained by on-the-job training at Army hospitals in which there are large psychiatric treatment centers. Usually, two to six of the newly commissioned medical officers who volunteer for such training are assigned to the psychiatric sections of the training hospitals, where they remain for the duration of their obligatory tour of service. This type of training has operated successfully to

[17] Forrer, G. R., and Grisell, J. L.: U.S. Army Psychiatric Training Program; Subsequent Nation-Wide Effects. Arch. Neurol. & Psychiat. 77: 218–222, February 1957.

fill the Army needs for additional psychiatrists and has also served to swell the ranks of civilian psychiatrists.

SUMMARY

In this chapter, the editor has endeavored to discuss what he has considered to be the major lessons learned by military psychiatry in World War II. Undoubtely, there are other and contrary valid opinions. However, he could not hope to cover the many innovations and improvisations developed by psychiatrists to cope with local problems be such problems either clinical or administrative. Unquestionably, ingenious techniques of therapy and unique methods of applying psychiatric skills to resolve particular military community problems were evolved by individual psychiatrists. However, only those lessons learned which had a widespread utilization or universal applicability could be included in this review.

Perhaps the most important contribution of military psychiatry of World War II has not been stated. This concerns the subtle or gradual orientation of psychiatry as a result of wartime experience toward considering the emotional problems of the individual within the context of his group and his social culture, instead of almost exclusive preoccupation with intrapsychic conflict or pathology. It might be said that World War I brought the psychiatrist from behind the mental asylum walls to practice in the community, whether in an office, a clinic, or a local general hospital. World War II forced the psychiatrist to function extramurally—where soldiers lived, worked, and fought. This experience provided a firsthand opportunity for the psychiatrist to observe the effects of the group process and its impact upon attitudes, values, and finally symptoms and behavior of individuals. Psychiatrists were then able to perceive and incorporate the contributions of other social sciences, such as sociology, social psychology, and anthropology, into the framework of psychiatry. Indeed, these wartime experiences may be said to have initiated the governing concepts and practices of social psychiatry, for in essence, military psychiatry is but a form of social psychiatry.

Wartime military psychiatrists quickly appreciated the potent effects upon individual behavior of morale, leadership, and group cohesiveness. They learned to work with command in implementing changes in rules and regulations designed to decrease noneffectiveness. Finally, the present focus of civilian psychiatry upon establishing community mental health centers which aim to provide consultative services to "caretakers" and community agencies and to render treatment "as far forward as possible" can be regarded as a logical extension of the insights achieved by military psychiatry in World War II.

APPENDIX A

Disqualifications and Discharges for Neuropsychiatric Reasons, World War I and World War II (A Comparative Evaluation)

Bernard D. Karpinos, Ph.D., and *Col. Albert J. Glass, MC, USA (Ret.)*

Repeated references have been made in several chapters of this volume to the rejection and discharge rates for neuropsychiatric reasons in World War I. During the mobilization and the early phases of World War II, these World War I rates were freely quoted by various civilian and military authorities, including psychiatrists, as evidence to support recommendations for increased or more comprehensive psychiatric screening at the time of examination for military service. Because the quoted World War I rates varied according to source material and, moreover, were frequently erroneously derived, owing to certain difficulties in obtaining statistical data for World War I that could be reliably compared with those of World War II, it was thought essential—for uniform and proper interpretation of these data—to present the following comparative evaluation of the neuropsychiatric selection and discharges in World War I and World War II:

DISQUALIFICATIONS FOR NEUROPSYCHIATRIC REASONS: WORLD WARS I AND II

World War I

General considerations.—On 16 April 1917, Congress declared war against Germany. On 17 May 1917, President Woodrow Wilson approved the selective service act providing for the registration of all males between the ages of 21 and 30, both inclusive. Of the approximately 10 million World War I registrants, comprising the first and second registrations, approximately 2.5 million registrants were medically examined at the local boards before 15 December 1917. Some 29.1 percent of these registrants were rejected on medical (including mental) grounds. Of the number who were found medically (physically and mentally) qualified for military service, 516,212 were called and entrained for mobilization camps before 31 December 1917.

On about 15 December 1917, all registrants of the first and second registration, not yet called to service, were placed in five classes on the basis of a special questionnaire obtained from each registrant with regard to his economic (industrial and agricultural) status. Class I included registrants liable for immediate military service (excluding those exempt on economic grounds). At that time, provisions were also made for using men who might not be qualified for full military service but who would qualify for limited military duty; that is, class B, the remedial group, and class C, the limited-service group. With the creation of the "B" and "C" groups, all registrants who had been previously disqualified for full military service, namely, all those included in the 29.1 percent previously rejected registrants, were reexamined, in addition to the examined class I men. As a result, 3,247,888 registrants were medically examined, or

reexamined, by the local boards after 15 December 1917, of whom 549,099 registrants were rejected for any (full or limited) military service. Obviously, the total manpower pool to which these rejected registrants relate includes both the registrants who were examined or reexamined, after 15 December 1917 (3,247,888 men), and the registrants that were found fit for military service and forwarded to mobilization camps (516,212) before that date; that is, a total of 3,764,100 registrants.

After 1 January 1918, a total of 2,150,555 class I men from the first and second registrations were called and sent to mobilization camps. This number, added to the men (516,212) who had been sent to camp before 15 December 1917, gives a total of 2,666,767 men of the first and second drafts who had been found medically (physically and mentally) fit by the local boards and sent to mobilization camps. This number does not include the third registration of 12 September 1918, which consisted of an additional 13 million men, of whom 140,000 were reported to camps for active duty; nor does it include voluntary enlistees and officer candidates.[1]

To determine his fitness for military service, a World War I registrant actually underwent two complete medical examinations; that is, one given by the local boards and another, if found medically qualified by the local board, at the mobilization camp.

Examinations by the local boards.—The examinations of World War I registrants for military service by the local boards were accomplished much in the same way as in the early days of World War II. The local boards of World War I thus faced similar problems and difficulties as those of World War II. The medical examinations at the local boards were conducted by local physicians. When considered necessary, such examinations included referral for specialist consultation by appropriate members of the medical advisory boards—a system quite similar to that which prevailed during the mobilization phase of World War II. As might have been expected, "the character of the examination varied with different boards and also at different periods of mobilization with changing orders from time to time relative to the standards for rejection and classification." [2]

With respect to neuropsychiatric evaluation at the local board level, it is highly improbable, except by some coincidence, that there were routine examinations by psychiatrists. However, many of the overt and more severe neurological and psychiatric disorders, such as epilepsy, mental deficiency, chronic alcoholism, and severe behavioral problems, must have been either recognized by the local board physicians or brought to their attention by collateral information from family physicians, family members, correspondence from hospitals, and general knowledge of such cases in the community. It is not surprising, therefore, that most of the neuropsychiatric disqualifications by the local boards were in the aforementioned diagnostic categories which did not require the diagnostic skills of a psychiatrist.

Examinations at mobilization camps.—Upon arrival at mobilization camps, the draftees [3] found fit for military service by the local boards were given another complete medical examination, including ordinarily a psychiatric evaluation. Inasmuch as the psychiatric program had not been fully established at the early phase of World War I, not all draftees of the first increments reporting to camps were given a routine neuropsychiatric examination by neuropsychiatrists.

In addition to the more effective psychiatric program that was eventually established, the general caliber of the medical examinations and the use of medical specialists at mobilization camps improved with time. For this reason, the routine examinations

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[1] Love, Albert G., and Davenport, Charles B.: Defects Found in Drafted Men. Washington: Government Printing Office, 1920, pp. 53–54. (The total figure (2,666,767) mentioned in this text is erroneously given in the cited publication as 2,666,867.)

[2] The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, p. 158.

[3] The term "draftee(s)" is used to indicate registrants who were processed through the Selective Service System (local boards), in distinction to volunteer registrants for enlistment.

at mobilization camps of men in the second draft were considerably more thorough than those of the first.

Draftees found unfit for military service at the mobilization camp were properly considered as rejections and returned to their local boards. Local boards, however, did not always take the decision of the mobilization camps as final and frequently, when called upon for another increment for men, would include, among the new increments, draftees previously rejected for neuropsychiatric reasons.[4]

Data relating to medical rejections.—Actually, there are no statistical data which would show, for World War I, the number of draftees who were rejected for military service for any specific diagnosis. The only basic source of such diagnostic data is the publication "Defects Found in Drafted Men."[5] But, as its very title suggests, this publication deals with defects, not men. Diagnostic distributions of the defects are shown in this publication separately for the various groups, as follows: A, fit for full military service; B, accepted for remediable treatment; C, accepted for limited service; D, rejected at mobilization camps; and Vg, rejected by local boards (tables IV and V in the publication). The distributions deal, hence, with the prevalence of defects—both nondisqualifying and disqualifying—among these various groups. For some draftees, more than one defect was reported.

Our immediate concern is with the rejected draftees (classes D and Vg), since the closest evaluation that could be made with respect to rejections for any diagnosis has to be based on the prevalence of these defects among these groups. As may be seen from the total given in the aforementioned table IV,[6] 698,718 defects were recorded for the draftees rejected by the local boards (Vg group), which counted, as previously stated, some 549,099 rejected men. In other words, 1.3 defects (= 698, 718/549,099) were recorded on the average for each draftee rejected by the local boards (Vg group). About the same proportional number of defects per rejected draftee were recorded for draftees rejected at the mobilization camps (class D). One of these defects recorded for rejected draftees must have been a disqualifying defect; the other defects could or could not have been disqualifying.[7]

Prevalence of neuropsychiatric defects.—The prevalence of neuropsychiatric defects among rejected draftees is presented in tables 1, 2, and 3, for neurological, psychiatric, and total neuropsychiatric disorders, respectively. Each table indicates both the number of recorded defects and their prevalence rates; namely, the number of defects among rejected draftees per 1,000 draftees examined—separately for those rejected by the local boards and those rejected at the mobilization camps. The rates shown under "total" represent "weighted" prevalence rates and not merely summations of the separate prevalence rates.[8]

In comparing the neuropsychiatric defects found at the local board level with those found at the mobilization camps (tables 1–3), it will be noted that the prevalence rate at the local boards for neurological disorders was 3.7 times as high as that at the mobilization camps; for psychiatric disorders, about twice as high; and about 2.5 times as high for total neuropsychiatric defects. The differences lie primarily in such diagnoses as epilepsy, mental deficiency, and psychoses which are more readily diagnosed

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[4] "Records were received in the Surgeon General's Office of men detected and discharged from as many as five different camps, each time by a different group of examiners." *In* The Medical Department of the United States Army in the World War, vol. X, p. 84.

[5] Love and Davenport, *op. cit.*

[6] *Ibid.*, p. 428.

[7] These data comprise the records of all draftees rejected by the local boards. The mobilization camp data are based on sample tabulations (about 74 percent) of all examination reports accomplished at these camps. Some 2 million records were tabulated, referred to as the "first million" which included the records of draftees examined before 1 May 1918, and "second million" which included the records of those examined after 1 May 1918.

[8] See "Source" to table 1, p. 764.

TABLE 1.—*Prevalence of neurological defects among draftees rejected for military service, World War I*

Diagnosis	Prevalence of defects					
	Local boards (Class Vg)		Mobilization camps (Group D)		Total (Class Vg and Group D)	
	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined
Epilepsy	12,377	3.29	1,699	0.87	14,076	4.31
Monoplegia	3,504	.93	135	.07	3,639	1.12
Speech, defective	2,211	.59	558	.28	2,769	.85
Hemiplegia and apoplexy	1,721	.46	112	.06	1,833	.57
Paraplegia	1,129	.30	23	.01	1,152	.36
Chorea	504	.13	78	.04	582	.18
Tabes dorsalis	425	.11	108	.06	533	.16
Neuritis	297	.08	101	.05	398	.12
Facial paralysis	208	.06	34	.02	242	.07
Muscle paralysis	181	.05	82	.04	263	.08
Multiple sclerosis	113	.03	147	.07	260	.08
Nerve, paralysis of	75	.02	53	.03	128	.04
Spinal cord, other diseases of	891	.24	173	.09	1,064	.33
Paralysis (location and causes not given)	1,249	.33	37	.02	1,286	.40
Nervous system, other, diseases of	2,403	.63	456	.23	2,859	.88
Total	27,288	7.25	3,796	1.94	31,084	9.58

Source: Adapted from: Love, Albert G., and Davenport, Charles B., Defects Found in Drafted Men. Washington: Government Printing Office, 1920, tables IV and V, pp. 424–433. The diagnoses listed here are shown in the source tables under section "V. *Nervous system, diseases of (all).*" The deaf and dumb, mute, deaf, and deformities and diseases of the spine, listed under this section, were excluded. The prevalence rates shown in the "Total" column are "weighted" rates and not mere summations of the separate rates of the V_g and D groups. (See *op. cit.*, pp. 55–58, for the method of calculation of these rates.)

at the local board level, no doubt because of information available at the community level. Conversely, for the less overt diagnoses and for those which are more difficult to identify, as psychoneurosis and character and behavior disorders (specifically, constitutional psychopathic states), the mobilization camps indicate higher prevalence rates (table 2).

The total prevalance rates among World War I rejected draftees were as follows: Neurological defects, 9.6; psychiatric disorders, 16.8; and total neuropsychiatric defects, 26.3; for 1,000 examined draftees (table 3).

Analogous prevalence data were published by Rollo H. Britten and George St. J. Perrott.[9] Their data were derived from the same source as the data presented here.[10] Britten and Perrott, however, confined their calculations to the results of the "second million," including local board examinations.[11] Furthermore, their detailed diagnostic distribution deals with the prevalence of defects among both rejected and limited-service men. No separate detailed data were published by them for rejected men. For comparable diagnoses of the neuropsychiatric defects, this report indicates a prevalence rate of 28.0 among rejected and limited-service draftees per 1,000 men examined—versus our prevalence of 26.3 among rejected draftees only. The corresponding prevalence rate for psychiatric reasons is 18.3—versus our prevalence rate of 16.8 for rejected draftees only.

[9] Britten, R. H., and Perrott, G. St. J.: Summary of Physical Findings on Men Drafted in World War. Pub. Health Rep. 56: 41–62, 10 Jan. 1941.

[10] The Medical Department of the United States Army in the World War, vol. X.

[11] The data in the present evaluation relate to both the first and the second millions. See footnote 7, p. 763.

TABLE 2.—*Prevalence of psychiatric defects among draftees rejected for military service, World War I*

Diagnosis	Prevalence of defects					
	Local boards (Class Vg)		Mobilization camps (Group D)		Total (Class Vg and Group D)	
	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined
Psychoses:						
Dementia praecox	1,407	0.37	689	0.35	2,096	0.65
Psychosis, manic-depressive	393	.10	190	.10	583	.18
Psychosis, alcoholic	34	.01	26	.01	60	.02
General paralysis of the insane	159	.04	89	.05	248	.08
Psychoses, other	3,445	.92	265	.14	3,710	1.14
Psychoneurotic disorders:						
Neurasthenia	812	.22	583	.30	1,395	.43
Psychoneurosis	424	.11	988	.50	1,412	.44
Hysteria	237	.06	330	.17	567	.17
Neurocirculatory asthenia	232	.06	504	.26	736	.23
Neurosis	251	.07	66	.03	317	.10
Psychasthenia	105	.03	143	.07	248	.08
Mental deficiency	33,636	8.94	5,459	2.78	39,095	12.06
Character and behavior disorders:						
Alcoholism	477	.13	281	.14	758	.23
Constitutional psychopathic states	562	.15	874	.45	1,436	.44
Enuresis	86	.02	148	.08	234	.07
Drug addiction	608	.16	812	.41	1,420	.44
Malingering	2	.00	4	.00	6	.00
Total	42,870	11.39	11,451	5.84	54,321	16.76

NOTE.—The entry .00 indicates a rate of more than zero but less than .005.

Source: Love and Davenport, *op. cit.* Except for "Alcoholism" and "Drug Addiction," which are listed in the source material under section "IV. *General diseases (other),*" these data are as listed under section "V. *Nervous system, diseases of (all),*" and section "VI. *Mental alienation.*"

TABLE 3.—*Prevalence of neuropsychiatric defects among draftees rejected for military service, World War I* [1]

Diagnostic categories	Prevalence of defects					
	Local boards (Class Vg)		Mobilization camps (Group D)		Total (Class Vg and Group D)	
	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined	Number	Rates per 1,000 examined
Neurological	27,288	7.25	3,796	1.94	31,084	9.58
Psychiatric:						
Mental deficiency	33,636	8.94	5,459	2.78	39,095	12.06
Other	9,234	2.45	5,992	3.06	15,226	4.70
Total	42,870	11.39	11,451	5.84	54,321	16.76
Grand total	70,158	18.64	15,247	7.78	85,405	26.34

[1] Derived from tables 1 and 2.

Ginzberg and his associates,[12] in comparing World War I and World War II data, indicate that the rejection rate in World War I for emotional disorders and mental or educational deficiency was 14 per 1,000 men examined.[13] These authors also used Love and Davenport's data and limited their calculations to the second million men, as did Britten and Perrott. Despite the fact that the second million would show, in general, higher rates, their rates for psychiatric reasons are somewhat lower than ours: 14 as reported by them, versus 17 reported by us for psychiatric disorders (table 3), per 1,000 examined draftees. In all probability, this is due to differences in the diagnoses included in their table.

It seems that these authors also mistook these data as rejection rates (men rejected), instead of prevalence rates of defects among rejected men. In doing so, they naturally overstated their rejection rates.

Rejections for neuropsychiatric reasons.—As previously emphasized, there are no data which would provide rejection rates by diagnosis. However, it may be justifiably assumed that the calculated average number of all defects per rejected draftee, namely, 1.3 defects per rejected draftee, holds for the neuropsychiatric defects.[14] On the basis of this assumption, the best estimates with respect to rejection rates for neuropsychiatric defects in World War I would hence be as follows: Neurological defects, 7.4; psychiatric disorders, 12.9; and total neuropsychiatric defects, 20.3 for 1,000 examined draftees—2.0 percent rejections for neuropsychiatric defects and disorders.[15]

Quoted data on World War I neuropsychiatric rejections.—The primary source for the repeatedly quoted World War I rejection rates for neuropsychiatric rejections is "Neuropsychiatry."[16] This publication gives extensive information on 69,394 individuals identified as having neuropsychiatric defects and disorders originating in the U.S. Army home forces. Of these individuals, 27,836 (or 40.1 percent)[17] were discovered during the routine examination upon arrival at the mobilization camps. These persons included both draftees and volunteers for enlistment, as well as commissioned officers. It was obviously not a homogeneous group, from the point of view of selection, since the processing procedures were different for these individuals. While only draftees found fit for military service by the local boards were sent to the mobilization camps, no such procedures existed in World War I with respect to volunteers or officer candidates. The latter groups were sent directly to the mobilization camps without any extensive preliminary examination. Naturally, more defects would be found at the mobilization camps among volunteers and officer trainees than among draftees prescreened by the local boards. Indeed, with respect to neuropsychiatric disorders, the total prevalence rate among volunteers was found to be 1½ times as high as that among draftees. The highest differences between these groups were for drug addiction, psychoses, and constitutional psychopathic states, diagnoses more readily eliminated at the local board level.[18]

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[12] Ginzberg, Eli, Anderson, James K., Ginsburg, Sol W., and Herma, John L.: Lost Divisions. New York: Columbia University Press, 1959.

[13] *Ibid.*, footnote 8, table 36, p. 143.

[14] There are supporting data which seem to justify such an assumption, from studies by B. D. Karpinos, as follows: (1) "Fitness of American Youth for Military Service" (Milbank Mem. Fund Quart., July 1960), covering the Korean War period (table 7); (2) "Qualification of American Youths for Military Service" (Medical Statistics Division, Office of The Surgeon General, Department of the Army, 1962), covering the 1953–58 period; and (3) unpublished data for World War II. These studies indicate ratios of prevalence rates to rejection rates for the neuropsychiatric defects identical to those for all defects. These studies indicate 1.2 disqualifying defects per disqualified examinee for all defects, as well as for neuropsychiatric disorders.

[15] These rates were obtained by dividing the prevalence rates, as shown in table 3, by 1.3; that is, assumed number of neuropsychiatric defects per rejected draftee.

[16] The Medical Department of the United States Army in the World War, vol. X.

[17] *Ibid.*, chart III, p. 164.

[18] *Ibid.*, pp. 160–163.

At any rate, only the individuals (the 40 percent) discovered on the routine examinations, upon arrival at the mobilization camps, could be properly designated as rejections. The remaining individuals (60 percent of the neuropsychiatrically unfit) were discovered by referral from medical officers, unit commanders, psychologists, and in connection with courts-martial and delinquency. Clearly, the latter group should be considered more rightly as discharges, rather than rejections.

Such a consideration can be supported by the distribution of these individuals by length of service (table 4). This distribution indicates that 21.3 percent of these men were discharged from the service after having between 1 and 3 months of service; 11.6 percent, between 4 and 6 months; 7.9 percent, between 7 and 12 months; 3.1 percent, between 1 and 2 years; and 1.7 percent over 2 years of service. Only slightly over one-half were discharged with under 1 month of service. Yet the quoted World War I rejection rate for neuropsychiatric reasons is based on the total number of these individuals. As stated in that publication:[19] "Assuming 3,500,000 as the total number examined, it is found that about 20 out of 1,000 were discovered to have some sort of nervous and mental disease * * *."[20] It is this oft quoted statement that has been the origin of the 2 percent figure, constantly quoted as the World War I rejection rate for neuropsychiatric disorders. It is by pure chance that this quoted rate for World War I, erroneously derived, so remarkably coincides with the actual World War I rejection rates.

World War II

Statistical data.—The disqualification rates for military service, especially those for neuropsychiatric reasons, fluctuated widely in World War II. Various rejection rates could be and have been used, depending on the period to which the rates relate. However, certain estimates have been published by Selective Service representing an overall distribution, covering the entire World War II period. These estimates are presented in condensed form in table 5, showing the distribution of the draftees classified as 4F, as of 1 August 1945, by wide causes of disqualification.

These data as reported by Selective Service were modified ("adjusted") by distributing the "obviously disqualifying" defects; namely, the disqualifications by the

TABLE 4.—*Distribution of neuropsychiatric cases by length of service prior to discovery, World War I* [1]

Length of service	Number	Percent
Under 1 month	35,123	50.6
1 to 3 months	14,770	21.3
4 to 6 months	8,019	11.6
7 to 12 months	5,512	7.9
1 to 2 years	2,168	3.1
Over 2 years	1,167	1.7
Unascertained	2,635	3.8
Total [2]	69,394	100.0

[1] Derived from: The Medical Department of the United States Army in the World War. Neuropsychiatry. Washington: U.S. Government Printing Office, 1929, vol. X, table 10, pp. 170–171.

[2] This table includes 27,836 cases (40.1 percent) which were discovered on routine examinations (*op. cit.*, table 8, p. 164).

[19] The Medical Department of the United States Army in the World War, vol. X, pp. 159–160.

[20] This rate was derived by dividing the total number of the neuropsychiatric cases, namely, 69,394 by 3,500,000, the total number examined.

local boards which represent some 11 percent of all rejections, by diagnostic categories.[21]

These "adjusted" estimates indicate that approximately 38 percent of the disqualified draftees were classified as 4F because of neuropsychiatric defects, as follows: For neurological reasons, 6 percent; for psychiatric reasons ("mental disease"), excluding mental deficiency, 18 percent; and for mental deficiency, 14 percent (table 5). It has been further estimated that some 30 percent of the draftees were classified 4F as of that period (table 6).

On the basis of the foregoing data (tables 5 and 6), the following World War II rejection rates for neuropsychiatric defects and disorders were derived (table 7): For

TABLE 5.—*Distribution of registrants, 18–37 years of age, in class IV–F and classes with "F" designation, by major disqualifying cause, as of August 1945, World War II*

Disqualifying cause	As reported [1]		Adjusted [2]	
	Number	Percent	Number	Percent
Nonmedical	76,300	1.6	67,300	1.6
Neuropsychiatric	1,767,900	36.6	1,846,000	38.2
Neurological	(235,400)	(4.9)	(277,300)	(5.7)
Mental disease	(856,200)	(17.7)	(876,600)	(18.2)
Mental deficiency [3]	(676,300)	(14.0)	(692,100)	(14.3)
Physical defects (excluding neuropsychiatric)	2,473,300	51.2	2,905,700	60.2
Manifestly disqualifying defects [4]	510,500	10.6	----------	0
Total	4,828,000	100.0	4,828,000	100.0

[1] Adapted from "Physical Examinations of Selective Service Registrants in the Final Months of the War." Medical Statistics Bulletin No. 4 (table 4, p. 36). Washington: National Headquarters, Selective Service System, 1946.

[2] Adjusted in distributing the "Manifestly disqualifying defects" by disqualifying cause and diagnosis, on the basis of a special study of the local board defects made by Bernard D. Karpinos, Ph. D., Medical Statistics Division, Office of The Surgeon General, Department of the Army.

[3] Includes (1) registrants with more than one disqualifying defect who were rejected for educational deficiency before 1 June 1943; (2) registrants rejected for failure to meet minimum intelligence standards, beginning on 1 June 1943; and (3) morons, imbeciles, and idiots rejected November 1940–July 1945.

[4] Refers to disqualifications by the local boards.

NOTE.—Figures in parentheses are subtotals.

TABLE 6.—*Disqualification for military service of registrants 18–37 years of age, by age, World War II*

Age group	Number per 100 physically examined
18 to 25	22.7
26 to 29	29.4
30 to 33	39.3
34 to 37	48.5
All ages	30.2

Source: Report of the National Headquarters, Selective Service System, as appeared in the Congressional Record, dated 8 Jan. 1947, vol. 93, No. 5. This source provides estimated number of men 18–37 years of age on 1 Aug. 1945, who had been physically examined for induction or enlistment and the number accepted and rejected (including percent), by age.

[21] This was done on the basis of a special study. *See* footnote 2, table 5.

neurological defects, 17.2; for total psychiatric disorders (mental disease, 55.0 percent, and mental deficiency, 43.2 percent), 98.2; and for total neuropsychiatric defects and disorders, 115.4 per 1,000 draftees examined.[22]

Comparison of World Wars I and II Disqualification Rates

For comparison, the World War I and World War II disqualification rates for neuropsychiatric reasons are both presented in table 7. As may be seen from this table, the World War II rejection rates for neurological defects were 2.3 times as high as those in World War I; the rejection rates for psychiatric disorders were 7.6 times as high in World War II as in World War I. Especially high were the rejection rates for psychiatric disorders ("mental disease"), excluding mental deficiency; they were 15.3 times as high in World War II as in World War I.

DISCHARGES FOR NEUROPSYCHIATRIC REASONS: WORLD WARS I AND II

Detailed diagnostic distributions of the individuals discharged for neuropsychiatric defects and disorders in World War I are presented in table 8; a distribution by diagnostic categories of those discharged for neuropsychiatric disorders in World War II is shown in table 9; and a comparison between these discharge rates for World Wars I and II is presented in table 10. In evaluating these data, it must be recognized that disability discharges in World War I included persons discharged for mental deficiency and character and behavior disorders, such as constitutional psychopathic states, alcoholism, drug addiction, and enuresis, who in World War II were primarily discharged from the service by administrative separations for inaptness, inadaptability, and undesirable habits and traits of character.

World War I Discharges

The psychiatric diagnostic categories of World War I were different from those of World War II. However, these were rearranged in table 8 to correspond as closely as possible to the World War II diagnostic classification.

TABLE 7.—*Rejections for military service because of neuropsychiatric defects, World Wars I and II*

Diagnosis	Number rejected per 1,000 draftees examined		Ratios of World War II to World War I rates[3]
	World War I[1]	World War II[2]	
Neurological defects	7.4	17.2	2.3
Psychiatric disorders:			
Mental disease	3.6	55.0	15.3
Mental deficiency	9.3	43.2	4.6
Total	12.9	98.2	7.6
Grand total	20.3	115.4	5.7

[1] Derived by dividing the prevalence rates, as shown in table 3, by 1.3.

[2] Derived by multiplying the "adjusted" percentages, as given in table 5, by .302, which is the proportion of draftees that could not qualify for military service (table 6).

[3] Obtained by dividing the World War II rates by those of World War I.

[22] For method of computation, see footnote 2, table 7.

TABLE 8.—*Disability discharges for neuropsychiatric reasons, World War I, 1 April 1917–31 December 1919*

Diagnosis	Number		Ratios per 1,000 mean strength per year	
	Total [1]	Enlisted men	Total [1]	Enlisted men
	Neurological disorders			
Epilepsy	5,417	5,404	1.31	1.38
Neuritis	892	874	.22	.22
Neuralgia	34		.01	
Paralysis without specified cause	379	375	.09	.10
Spinal cord, diseases of	340	336	.08	.09
Meningitis, simple	79	79	.02	.02
Apoplexy	178	176	.04	.04
Chorea	157	157	.04	.04
Facial paralysis	57	55	.01	.01
Multiple sclerosis	194	193	.05	.05
Locomotor ataxia	127	125	.03	.03
Defective speech	150	149	.04	.04
Jacksonian epilepsy	49	49	.01	.01
Encephalitis	18	16	.00	.00
Paraplegia	40	39	.01	.01
Nervous system, other diseases of	502	493	.12	.13
Total	8,613	8,520	2.09	2.17
	Psychiatric disorders			
Psychoses	8,957	8,870	2.17	2.26
Dementia praecox	(5,797)	(5,771)	(1.40)	(1.47)
Psychosis, manic-depressive	(1,711)	(1,673)	(.41)	(.43)
Psychosis, alcoholic	(177)	(177)	(.04)	(.05)
General paralysis of the insane	(220)	(213)	(.05)	(.05)
Psychoses, other	(1,052)	(1,036)	(.25)	(.26)
Psychoneurotic disorders	9,388	9,265	2.27	2.36
Neurasthenia	(2,259)	(2,199)	(.55)	(.56)
Psychoneurosis	(2,616)	(2,591)	(.63)	(.66)
Hysteria	(2,139)	(2,124)	(.52)	(.54)
Neurocirculatory asthenia	(1,821)	(1,816)	(.44)	(.46)
Shellshock	(63)	(60)	(.02)	(.02)
Neurosis	(157)	(155)	(.04)	(.04)
Psychasthenia	(333)	(320)	(.08)	(.08)
Mental deficiency	10,658	10,654	2.58	2.72
Character and behavior disorders	6,090	6,063	1.48	1.55
Alcoholism	(455)	(453)	(.11)	(.12)
Constitutional psychopathic state	(3,709)	(3,693)	(.90)	(.94)
Enuresis	(734)	(733)	(.18)	(.19)
Drug addiction	(1,190)	(1,184)	(.29)	(.30)
Malingering	(2)		(.00)	(0)
Total	35,093	34,852	8.50	8.89

[1] Includes both officers and enlisted men.

NOTE.—The entry .00 indicates a rate of more than zero but less than .005. Figures in parentheses are subtotals.

Source: Adapted from: The Medical Department of the United States Army in the World War. Statistics. Washington: Government Printing Office, 1925, vol. XV, pt. 2, tables 50–51.

The presented discharges of World War I (table 8) deal separately with the "Total," which includes both officers and enlisted men, and with "Enlisted men." For comparison with World War II data, only enlisted men are to be considered. In terms of broad diagnostic categories, the World War I disability discharge rates for enlisted men were as follows: For neurological disorders, 2.2; for total psychiatric disorders (psychoses, 2.3; psychoneurosis, 2.4; mental deficiency, 2.7; and character and behavior disorders, 1.5), 8.9; and for total neuropsychiatric defects and disorders, 11.1 per 1,000 mean strength per year, or 1.1 percent.

These data clearly indicate that neuropsychiatric discharges in World War I were only slightly above 1 percent (1.1 percent)—a rate significantly less than the rate of 3 percent disability discharges, cited by Bowman (p. 157). If the neurological dis-

TABLE 9.—*Disability and administrative separations of enlisted men for neuropsychiatric reasons, World War II (1942–45)*

Type of separation and diagnosis	Number	Rate per 1,000 mean strength per year
	Disability separations [1]	
Neurological disorders:		
Epilepsy	14,633	0.6
Other	35,472	1.6
Total	50,105	2.2
Psychiatric disorders:		
Psychosis	59,935	2.6
Psychoneurosis	259,432	11.4
Character and behavior disorders	2,930	.1
Disorders of intelligence	2,650	.1
Other psychiatric disorders	281	.0
Total	325,228	14.2
Grand total	375,333	16.4
	Administrative separations	
Inaptitude or unsuitability	122,464	5.3
Unfitness	40,655	1.8
Total	163,119	7.1
	Total separations [2]	
Neurological	50,069	2.2
Psychiatric (disability and administrative separations)	488,347	21.3
Total	538,416	23.5

[1] Based on individual medical records. These data differ somewhat from those published in "Health of the Army," vol. 1, Report No. 2, 31 Aug. 1946, which were preliminary data based on reports received from the Office of The Adjutant General.

[2] The following sources were used in the preparation of these data: Adjutant General's Reports: ETM–54c and 59c—for the earlier years, and "Strength of the Army" STM–30, Adjutant General's Office, Machine Records Branch—afterward. In each case, the latest available statistics were used.

NOTE.—The entry .0 indicates a rate of more than zero but less than .05.

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TABLE 10.—*Discharges of enlisted men for neuropsychiatric reasons, World Wars I and II*

Diagnosis	Rates per 1,000 mean strength per year		Ratio of World War II to World War I rates [1]
	World War I [2]	World War II [3]	
Neurological disorders	2.2	2.2	1.0
Psychiatric disorders:			
Psychosis	2.3	2.6	1.1
Psychoneurosis	2.4	11.4	4.8
Other[4]	4.2	7.3	1.7
Total	8.9	21.3	2.4
Grand total	11.1	23.5	2.2

[1] Computed by dividing the World War II rates by those of World War I.

[2] Taken from table 8 (column "Enlisted men").

[3] Taken from table 9. The World War II rates presented here differ from those published by Ginzberg *et al.* (*op. cit.*, table 12, p. 62) primarily for the following reason: In calculating their rates, Ginzberg *et al.* used as their population base the number of enlisted men who served, namely, the enlisted male strength as of 31 December 1941 plus enlisted male accessions during the 1942–45 period, while we used the mean strengths of the period. Our procedure was dictated by the fact that the World War I discharge rates were also related to mean strength.

[4] "Other" includes character and behavior disorders, disorders of intelligence (mental deficiency), and other psychiatric disorders, as well as the World War II administrative separations for inaptitude or unsuitability, and unfitness (table 9).

charges are excluded, a rate of less than 1 percent (0.89 percent) is obtained for psychiatric discharges in World War I.

World War II Discharges

The World War II discharges for neuropsychiatric reasons include disability separations for neuropsychiatric defects and disorders as well as administrative separations for inaptitude, unsuitability, and unfitness, as previously indicated. The underlying causes of the latter separations are primarily character and behavior disorders. In terms of broad diagnostic categories, the World War II discharges for neuropsychiatric reasons were as follows: For neurological defects, 2.2; for psychiatric disorders (including disability and administrative separations), 21.3; and for total neuropsychiatric defects and disorders, 23.5 per 1,000 mean strength per year.

Comparison of World Wars I and II Discharge Rates

As may be seen from table 10, the total discharge rate for neuropsychiatric reasons in World War II was about 2.2 times as high as in World War I. However, the discharge rates for neurological defects and for psychoses were practically identical in both wars.

The main differences in the discharge rates of World Wars I and II were with respect to the psychoneurosis and "other" psychiatric disorders, which mainly consisted of character and behavior disorders. The discharge rate for psychoneurotic disorders was 4.8 times as high in World War II as in World War I. For "other" psychiatric disorders, the World War II discharge rate was 1.7 times as high as that of World War I.

GENERAL COMMENT

Many factors were responsible for the higher disqualification and discharge rates for neuropsychiatric reasons in World War II than in World War I. With respect to

the disqualification rates, the foremost factor was, of course, the experience of World War I. That experience led to a philosophy, adopted in World War II, that the neuropsychiatric selection standards and screening procedures should be stricter than they had been. Besides, there have been improvements in the techniques of recognizing neuropsychiatric disorders. But these, and similar factors that obviously contributed chiefly to the increased disqualification rates of World War II, are exogenous factors, not germane to the incidence of neuropsychiatric disorders per se. Yet, these differences have been interpreted often, and unqualifiedly, as an index of increasing incidence of neuropsychiatric disorders in our population during that period. Obviously, such an interpretation is hardly justifiable. It is as misleading as would be an inference, drawn from the decreased disqualification rates for neuropsychiatric reasons during the Korean War period, that the incidence of these disorders is now decreasing. Owing to the liberalized policy with respect to psychiatric standards and screening procedures, which became effective after World War II, the disqualification rates for psychiatric reasons during the Korean War was 1.9 percent, compared with 5.5 percent in World War II; that is, about one-third of what it was in World War II.[23]

Similarly, in comparing the higher discharge rates of World War II with those of World War I, the relative severity of these wars, their relative duration, the number and geographic locations of their combat zones, and probably, above all, the discharge procedures that prevailed in World War II are all factors which must be taken into account in such an evaluation. (See chapter IX, "Hospitalization and Disposition.")

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[23] Karpinos, B. D.: Fitness of American Youth for Military Service. Milbank Mem. Fund Quart. 38: 213–247, July 1960.

APPENDIX B

Mobilization Regulations Pertaining to Mental and Nervous Diseases and Neurological Disorders

The following are extracts from MR 1–5, 5 December 1932, and from MR 1–9, 31 August 1940 and 15 March 1942, respectively, pertaining to mental and nervous diseases and neurological disorders:

MOBILIZATION REGULATIONS)
)
No. 1–5)

WAR DEPARTMENT,
Washington, December 5, 1932

STANDARDS OF PHYSICAL EXAMINATION DURING THOSE MOBILIZATIONS FOR WHICH SELECTIVE SERVICE IS PLANNED

* * * * * * *

SEC. 215. MENTAL AND NERVOUS DISEASES.

a. Registrants who on examination show the following conditions shall be unconditionally accepted for general military service:

(1) A normal nervous system.

(2) Who appear to have normal understanding, whose speech can be understood, who have no definite signs of organic disease of the brain, spinal cord, or peripheral nerves, and who are otherwise mentally and physically fit.

(3) Hysterical paralysis or hysterical stigmata and local muscular spasms which do not cause mental or physical defects disqualifying for general military service.

(4) Muscular tremors of moderate degree.

b. Registrants who on examination are found to suffer from the following defects of the nervous system, who are otherwise mentally and physically fit, may be accepted for special and limited military service.

(1) Stuttering and stammering of a degree disqualifying for general military service but which has not prevented from successfully following a useful vocation in civil life.

(2) Hysterical paralysis or hysterical stigmata of a degree disqualifying for general military service, but not of a character to prevent the registrants from successfully following a useful vocation in civil life.

(3) Tremors of such marked degree that they disqualify for general military service but have not prevented the registrants from following a useful vocation in civil life.

(4) Drug addiction, including the habitual use of opium and its derivatives and cocaine.

c. Registrants who on examination are found to suffer from the following defects shall be unconditionally rejected for all military service:

(1) Insanity.

(2) Epilepsy.

(3) Idiocy.

(4) Imbecility.

(5) Chronic alcoholism.

(6) Stuttering or stammering to such a degree that the registrant is unable to express himself clearly or to repeat commands or to demand the countersign.

(7) Constitutional psychopathic state.
(8) Chronic essential chorea.
(9) Tabes (locomotor ataxia).
(10) Cerebrospinal syphilis.
(11) Multiple sclerosis.
(12) Paraplegia or hemiplegia.
(13) Syringomyelia.
(14) Muscular atrophies and dystrophies which are obviously disqualifying.
(15) Hysterical paralysis or hysterical stigmata so serious that these defects are disqualifying for military service.
(16) Neuritis or neuralgia which is not temporary in character and which has progressed to such a degree as to prevent the registrant from following a useful vocation in civil life.
(17) Brain tumors.

* * * * * * *

SEC. 223. NOTES ON MALINGERING.

a. Malingerers may be divided into three general groups:

(1) Real malingerers with nothing the matter with them, who injure themselves, or make allegations respecting diseases or such condition as drug taking, or who counterfeit disease with full consciousness and responsibility; all for the purpose of evading military service. Many of these have been coached.

(2) Psychoneurotics who are natural complainers and try to get out of every disagreeable thing in life. Perhaps only partially conscious of the nature or the seriousness of what they do and only partly responsible. In many the motives are not persistent and many can be made into good soldiers.

(3) Confirmed psychoneurotics with long history of nervous breakdown and illnesses who behave like group (1) but more persistently and from whom not much can be expected in the way of reconstruction.

b. The detection and management of medical cases depend upon the absence of positive findings in one who presents the general characteristics of the malingerer. There is especial need for the physical examination to be thorough in this group. Some of the cardiac cases at first regarded as malingerers were pronounced later by the cardio-vascular board to have mitral stenosis, and similarly proper tests have shown the existence of gastric ulcer in cases which were under suspicion of fraud. The estimation of the reality of rheumatic pains is always a difficult matter.

c. Surgical.—Under this are included old scars and injuries of the bones, fractures, and orthopedic conditions.

d. Artificially created conditions.—Men shoot or cut off their fingers or toes, practically always on the right side, to disqualify themselves for service. Sometimes they put their hands under cars for this purpose. Many men have their teeth pulled out. Retention of urine is simulated. Egg albumin is injected into the bladder or put in urine. Glucose is added to urine. Digitalis, thyroid gland preparations, and strophanthus are taken to cause disturbance of the heart and cantharides to cause albuminuria. The skin is irritated by various substances which are also injected under it to create abscesses. Various substances are taken to bring about purging. An appearance of hemoptysis may be produced by adding blood, either human or that of animals, to the sputa. Sometimes merely coloring matter is added. Those who can vomit voluntarily what they swallow use the same means to create the appearance of hematemesis. Similarly, coloring matters may be added to the stools. Mechanical and chemical irritants are made use of to cause inflammation about practically all the body orifices. Jaundice may be simulated by taking picric acid. Crutches, spectacles, trusses, strappings, etc., are made use of to create the appearance of disability.

e. Detection.—Wounds are rarely self-inflicted when witnesses are present, con-

sequently it is almost impossible to be certain of the motive behind these. Artificial jaundice is to be recognized by the demonstration of picric acid in the urine.

f. Bed wetting.—A frequent complaint among registrants for military service but not a cause of rejection.

g. The surest means of detecting malingering is a thorough understanding by the examining physician of the types of people who actually do it—and the way they behave. It is only in the feigned diseases of the eye and ear that special tests are required. Observation in hospital is necessary in difficult cases. The vast bulk of malingerers are those who exaggerate some actual defect, and the problem for the examining physician is to decide whether the defect complained of is sufficient cause for rejection for service. Persons of intelligence and education have more difficulty in deceiving, as they are bound to express themselves freely. If they are reticent in these matters they arouse suspicion by their reticence. Those who talk freely may be counted on to say things at variance with the existence of the disease of which they complain.

h. Whenever it shall appear to an examining physician that a registrant is endeavoring to escape service by malingering, if otherwise mentally and physcally fit, he shall be accepted. A full statement of the facts shall be prepared and forwarded to the Director of Selective Service.

SEC. 224. NERVOUS AND MENTAL.

a. Insanity.—Rarely feigned by registrants and then of an extremely silly, foolish type. In cases of doubt, hospital observation is necessary with verified past records. Mental defects are frequently feigned, especially by illiterates. Organic diseases of the central nervous system cannot be simulated.

b. Pain and hyperesthesia.—The most frequent of all complaints. History inconsistent, ordinary traces of suffering absent. Absence of other symptoms usually accompany types of pain complained of. Absence of objective evidence of localized pains. Note behavior when the registrant believes himself unobserved.

c. Anesthesia.—Complaint of anesthesia itself creates a suspicion of malingering as most patients with anesthesia are ignorant of it.

d. Epilepsy.—Men who have sustained head injury are very apt to claim fits. These complaints may be in reference to grand mal or petit mal. Petit mal attacks are spoken of as fainting attacks. In grand mal attacks there is loss of pupil response to light, knee jerks are lost, and the Babinski reflex may be present.

e. Hysteria.—Not feigned in itself, but its existence creates confusion as to malingering. The question to be decided is whether the registrant is too seriously affected with the neurosis to be useful as a soldier. Often, even when the physical symptoms are most pronounced (paralysis), cure is still possible.

f. Stiff backs.—Stiff back is a frequent symptom of hysteria in mobilization among selected men. In cases of this kind organic disease of the vertebrae can and should be excluded, if necessary, by the X-ray.

MOBILIZATION REGULATIONS) WAR DEPARTMENT
)
No. 1–9) WASHINGTON, *August 31, 1940*

STANDARDS OF PHYSICAL EXAMINATION DURING MOBILIZATION

* * * * * * *

SECTION XIX

MENTAL AND NERVOUS DISORDERS

	Paragraph
Class 1–A	75
Class 1–B	76
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75. Class 1–A.—*a.* A normal nervous system.

b. Registrants who appear to have normal understanding, whose speech can be understood, who have no definite signs of organic disease of the brain, spinal cord, or peripheral nerves, and who are otherwise mentally and physically fit.

c. Muscular tremors of moderate degree, unless malingering is definitely excluded.

76. Class 1–B.—*a.* Stuttering and stammering of a degree disqualifying for general military service but which has not prevented registrants from successfully following a useful vocation in civil life.

b. Tremors of such marked degree that they disqualify for general military service but have not prevented the registrants from following a useful vocation in civil life.

77. Class 4.—Any serious mental or neurological disorder such as—

a. Insanity.

b. Epilepsy.

c. Post-encephalitic syndrome.

d. Imbecility.

e. Drug addiction, including the habitual use of opium and its derivatives and cocaine.

f. Chronic alcoholism.

g. Stammering to such a degree that the registrant is unable to express himself clearly or to repeat commands.

h. Psychoneuroses and constitutional psychopathic states providing the diagnosis is clearly established and in the opinion of the medical examiner precludes the successful performance of military duty.

i. Chronic essential chorea.

j. Syphilis of central nervous system.

k. Post-traumatic cerebral syndrome.

l. Multiple sclerosis.

m. Paraplegia or hemiplegia.

n. Syringomyelia.

o. Muscular atrophies and dystrophies which are obviously disqualifying.

p. Hysterical paralysis.

q. Neuritis or neuralgia which is not temporary in character and which has progressed to such a degree as to prevent the registrants from following a useful vocation in civil life.

r. Brain tumors.

s. Cerebral arteriosclerosis.

t. Sexual perversion.

78. Diagnostic criteria.—In arriving at decisions concerning nervous or mental defects, the following criteria may be of assistance:

a. Insanity.—All registrants should be considered insane who are committed, or who have been committed, to a licensed public institution for the care of the insane. The examining physicians may require proof in the form of verified records of commitment by the proper State authorities to verify the statements of the registrants.

(1) *Dementia praecox.*—Look for indifference, apathy, withdrawal from environment, ideas of reference and persecution, feelings of the mind being tampered with, or thought being controlled by hypnotic spiritualistic, or other mysterious agencies, hallucinations of hearing, bodily hallucinations, frequently of electrical or sexual character; meaningless smiles; in general, inappropriate emotional reactions and lack of connectedness in conversation. There may be sudden emotional or motor outbursts. The history of family life and of school, vocational, and personal career will usually show erratic and more or less irrational conduct.

(2) *Manic-depressive insanity.*—Look for mild depression, with or without feeling of inadequacy, or mild manic states with exhilaration, talkativeness, and overactivity.

(3) *Paresis.*—The diagnosis of paresis may be made when at the examination of

the registrant a majority of the following signs and symptoms are demonstrated: Argyll-Robertson pupil, facial tremor, speech defect in test phrases and in the slurring and distortion of words in conversation; writing defects, consisting of omissions and the distortion of words; apathetic or depressed or euphoric mood. These registrants may show memory loss or discrepancies in relating facts of life; the knee jerks may be plus, minus, or normal.

b. Epilepsy.—The registrant will not be considered an epileptic unless the claim is substantiated by characteristic scars on the tongue, face, or head, or if the examining physician is in doubt, by properly certified proof.

c. Imbecility.—A registrant will be declared an imbecile who has been so defective in mind from birth or early age as to be incapable of earning a livelihood but at the same time is able to guard himself against common physical danger.

d. Chronic alcoholism.—(1) A registrant will be declared a sufferer from chronic alcoholism when he presents a majority of the following symptoms and signs: Suffused eyes; prominent superficial blood vessels of nose and cheek; flabby, bloated face; red or pale purplish discoloration of mucous membrane of the pharynx and soft palate; muscular tremor of the protruded tongue and extended fingers; tremulous handwriting.

(2) The history of evidence presented that the registrant has been frequently and grossly intoxicated is not of itself sufficient proof for the diagnosis of chronic alcoholism.

e. Tabes.—The diagnosis of this disease should be made when, at the examination of the registrant, several of the following signs and symptoms are present: Argyll-Robertson pupil; absent knee jerks; positive Romberg, ataxic gait (especially when the eyes are closed); hypotonia; and anesthetic areas of the skin. The history of tabes is usually that of slow progression, of failing sexual power, and pains in the legs or back which are often described as rheumatism.

f. Cerebrospinal syphilis.—The prominent diagnostic signs and symptoms are headaches, varying deep and superficial reflexes, pupillary changes, ptosis, ocular palsies, facial weakness; the mental state may be normal, dull, or apathetic. Comparative motor weakness may involve one side of the body or one extremity.

g. Multiple sclerosis.—The diagnosis of this disease rests upon the following signs and symptoms: Intention tremor, nystagmus, absent abdominal reflexes, increased tendon reflexes, and scanning speech; in cases of this kind the history obtained is not characteristic, but sometimes there may be a history of urinary disturbances.

h. Paraplegia.—The diagnosis of paraplegia from whatever cause will rest upon weakness of the lower extremities, associated with loss of or increased knee jerks, Babinski reflex, or disturbance of the sphincters of the rectum and bladder, with or without girdle sensations. Sensory disturbance of the skin may or may not be present. Muscle sensibility may be diminished.

i. Syringomyelia.—Syringomyelia is usually evidenced by more or less loss of power and atrophy of groups of muscles of one or more extremities; disturbance of the sensations of the skin, more especially in the form of analgesias, and diminution of the temperature sense; if in the upper dorsal cord, often associated with stooped shoulder posture; if in the lower dorsal, with weakness in one or both lower extremities.

j. Muscular atrophies and dystrophies.—The signs and symptoms of muscular atrophies and dystrophies are: Atrophies of the small muscles of the hand and of the muscle groups of the shoulder; fibrillary twitchings. The history of these defects rarely furnishes reliable data, although it will usually be found that the registrant has shown evidences of awkwardness. There is never a history of pain in the affected muscles.

k. Multiple neuritis.—The chief manifestations are more or less pain in the course of the affected nerves, with tenderness over the trunks of the nerves and of the muscles supplied by them; lessened muscular power of varying degrees; more or less atrophy of muscles, with or without contraction, and evidences of trophic changes of the skin. The reflexes, deep and superficial, may be diminished or absent; the sphincters are not involved.

79. Sequelae of organic neurological disease.—Certain after-effects of organic nervous disease need not be causes for rejection, provided—

a. That the disease is no longer active and is not likely to recur.

b. That the effect left by it does not prevent a satisfactory fulfillment of military duties. Examples of such conditions are paralysis of a few unimportant muscles following poliomyelitis, slight unilateral hypertonicity as a result of an infantile hemiplegia in a man now robust, and various traumatic conditions.

Section XX
PURPOSELY CAUSED PHYSICAL DEFECTS

Paragraph
Report of apparently purposely caused defects 80

80. Report of apparently purposely caused defects.—Whenever it shall appear to an examining physician that a registrant is suffering from self-inflicted or purposely caused physical defects which, under the standards of physical examination prescribed herein, would render him disqualified for military service of any kind, a full statement of the facts and of the condition of the registrant and of the examining physician's recommendation will be prepared and submitted to the Director of Selective Service or other designated authority for a waiver of the physical defects, if recommended, so that the registrant may be compelled to render military service.

Section XXI
NOTES ON MALINGERING

Paragraph
Types of malingerers 81
Feigned medical diseases 82
Feigned surgical conditions 83
Nervous and mental feigned illness 84
* * * * * * *
Bed wetting 87
General considerations 88

81. Types of malingerers.—Malingerers may be divided into three general groups.

a. Real malingerers with nothing the matter with them, who injure themselves, or make allegations respecting diseases or such condition as drug taking, or who simulate disease with full consciousness and responsibility—all for the purpose of evading military service. Many of these will have been coached.

b. Psychoneurotics who are natural complainers and try to get out of every disagreeable thing in life; perhaps only partially conscious of the nature of the seriousness of what they do and only partly responsible. In many the motives are not persistent and many can be made into good soldiers.

c. Confirmed psychoneurotics with long history of nervous break-downs and illnesses who behave like group *a* above but more persistently and from whom not much can be expected in the way of reconstruction.

82. Feigned medical diseases.—*a.* The detection and management of malingerers simulating medical diseases depend upon the absence of positive findings in an individual who presents the general characteristics of the malingerer. There is especial need for the physical examination to be thorough in this group. Some of the cardiac cases at first regarded as malingerers may later be found to have mitral stenosis or bacterial endocarditis. Similarly, proper tests may show the existence of peptic ulcers in those suspected of feigning digestive abnormalities. The estimation of the reality of rheumatic pains is always a difficult matter.

b. Tachycardia and thyrotoxicosis may be temporarily induced by ingestion of drugs, such as thyroid extract. Egg albumin or sugar may be added to urine. Undiluted canned milk may be made to simulate urethral discharge. Cantharides may

be taken to cause albuminuria. Digitalis and strophanthus may be taken to cause abnormal heart findings. The skin may be irritated by various substances. Cathartics may be taken to bring about purging or to simulate a chronic diarrhea. An appearance of hemoptysis may be produced by adding blood, either human or that of animals, to the sputa. Sometimes merely coloring matter is added. Those who can vomit voluntarily what they swallow use the same means to create the appearance of hematemesis. Similarly, coloring matter may be added to the stools. Mechanical and chemical irritants are made use of to cause inflammation about practically all the body orifices. Jaundice may be simulated by taking picric acid. Crutches, spectacles, trusses, strappings, etc., are made use of to create the appearance of disability. Artificial jaundice is recognized by demonstration of picric acid in the urine.

83. Feigned surgical conditions.—Under this are included old scars and injuries of the bones, fractures, and orthopedic conditions. Men may have teeth extracted in effort to evade military service. Others may shoot or cut off their fingers or toes, practically always on the right side, to disqualify themselves for service. Some may put their hands under cars for this purpose. Retention of urine may be simulated. Substances may be injected under the skin to create abscesses. Crutches, braces, strappings, or trusses may be used to give the appearance of disability. Wounds are rarely self-inflicted when witnesses are present; consequently it is almost impossible to be certain of malingering in some cases.

84. Nervous and mental feigned illness.—*a. Insanity.*—Rarely feigned by registrants and then of an extremely silly, foolish type. In case of doubt, hospital observation is necessary, with verified past records. Mental defects are frequently feigned, especially by illiterates. Organic diseases of the central nervous system cannot be simulated.

b. Pain and hyperesthesia.—The most frequent of all complaints. History inconsistent, ordinary traces of suffering absent. Absence of other symptoms usually accompanies types of pain complained of. Absence of objective evidence of localized pains. Note behavior when the registrant believes himself unobserved.

c. Anesthesia.—Complaint of anesthesia itself creates a suspicion of malingering as most patients with anesthesia are ignorant of it.

d. Epilepsy.—Men who have sustained head injury are very apt to claim fits. These complaints may be in reference to grand mal or petit mal. Petit mal attacks are spoken of as fainting attacks. In grand mal attacks there is loss of pupil response to light, knee jerks are lost, and the Babinski reflex may be present.

e. Hysteria.—Not feigned in itself, but its existence creates confusion as to malingering. The question to be decided is whether the registrant is too seriously affected with the neurosis to be useful as a soldier. (See par. 77*h*.)

f. Stiff back.—Stiff back is a frequent symptom of hysteria in mobilization among selected men. In cases of this kind, organic diseases of the vertebrae can and should be excluded, if necessary, by X-ray.

* * * * * * *

87. Bed wetting.—Enuresis, either real or simulated, may be a frequent complaint among registrants for military service, but it is *not* a cause for unconditional rejection. Bed wetters may be placed in class 1–A or 1–B depending upon the apparent significance or severity of the disorder.

88. General considerations.—*a.* The surest means of detecting malingering is a thorough understanding by the examining physician of the types of people who actually do it, and the way they behave. It is only in the feigned diseases of the eye and ear that special tests are required. Observation in hospital is necessary in difficult cases. The vast bulk of malingerers are those who exaggerate some actual defect, and the problem for the examining physician is to decide whether the defect complained of is sufficient cause for rejection for service. Persons of intelligence and education have

more difficulty in deceiving, as they are bound to express themselves freely. If they are reticent in these matters they arouse suspicion by their reticence. Those who talk freely may be counted on to say things at variance with the existence of the disease of which they complain.

b. Whenever it shall appear to an examining physician that a registrant is endeavoring to escape service by malingering, if otherwise mentally and physically fit, he will be accepted. A full statement of the facts will be prepared and forwarded to the Director of Selective Service.

MOBILIZATION REGULATIONS NO. 1–9

WAR DEPARTMENT,
WASHINGTON, *March 15, 1942.*

STANDARDS OF PHYSICAL EXAMINATION DURING MOBILIZATION

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SECTION XIX
NEUROLOGICAL DISORDERS

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82. Methods of examination.—*a.* In order to detect the presence of certain common neurological diseases, particularly epilepsy, post-encephalitic and post-traumatic syndromes, multiple sclerosis, drug addiction, and hysteria, information regarding the life history of the individual is essential. The following should therefore be inquired into: Convulsions, fainting spells, attacks of unconsciousness, routine use of any medicines, hospitalization, severe head injury, and educational and occupational history.

b. The neurological examination will be conducted as follows: The individual will be examined stripped. He will walk a straight line at a brisk pace with his eyes open, stop, and turn around. He will then return in the same manner with his eyes closed, stop, and turn around. Look for spastic, ataxic, incoordinate or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movements; undue difference in performances with the eyes open and closed. The individual will then stand erect, feet together, arms extended in front. Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors or other involuntary movements. With eyes closed he will then touch his nose with the right and then the left index finger. Look for ataxia, tremors, overshooting, particularly at the end of the movement. Examine joint and spine movement and muscle condition. Look for muscular atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement and spine stiffness. As to pupils, look for irregularity, inequality, diminished or absent contraction to light; movements of eyes, facial muscles, and tongue. Look for strabismus, ptosis, sustained nystagmus, tremors of retracted lips, asymmetry or tremors of face or tongue. Sensation will be examined by pricking lightly each side of the forehead, bridge of nose and chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists by tuning fork. With the eyes closed, he will run each heel from the opposite knee to the ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and sense of position, and ataxia. Knee jerks and plantar reflexes should be tested. When indicated, appropriate laboratory tests and X-ray examinations will be made.

83. Class 1–A.—These registrants present—

a. A healthy nervous system as manifested by absence of signs of disease of the brain, spinal cord, cranial and peripheral nerves.

b. Certain variations clearly within physiological limits such as minor tremors.

c. Inconsequential paralyses resulting from old poliomyelitis or lesions of the peripheral nerves not likely to interfere with military duties.

84. Class 1–B.—Individuals who present muscular tremors or local paralyses due to old poliomyelitis or nonprogressive disease of the spinal cord or peripheral nerves of such marked degree that they disqualify for general military service but have not prevented the individual from successfully following a useful vocation in civil life.

85. Class 4.—Any serious neurological disorder such as—

a. Neurosyphilis of any form (general paresis, tabes dorsalis, meningo-vascular syphilis).

b. The epilepsies.

c. Paralysis agitans, post-encephalitic syndromes, athetosis, chorea, spasmodic torticollis, familial ataxia.

d. Post-traumatic cerebral syndrome.

e. Multiple sclerosis, encephalomyelitis.

f. Diffuse muscular atrophies or dystrophies of any type (with the exception of extremely mild residuals of poliomyelitis).

g. Chronic or recurrent neuritis or neuralgia of an intensity sufficient to prevent the individual from following a useful vocation in civil life. Multiple neuritis.

h. Cerebral arteriosclerosis, vascular accidents of all types.

i. Spina bifida, if associated with neurological manifestations. Meningocele, even if uncomplicated.

j. Other chronic degenerative diseases of the brain and spinal cord.

86. Diagnostic criteria.—The following brief summary of diagnostic criteria is intended as a general guide for examiners. It includes the common manifestations of the more usual neurological disorders, but it is not intended to cover all diagnostic criteria or all neurological disorders.

a. Syphilis of central nervous system.—(1) *General paresis or meningo-encephalitic syphilis.*—Look for unequal, irregular or sluggishly reacting pupils or Argyll-Robertson pupil; facial tremor; speech defect in test phrases and in the slurring and distortion of words in conversation; writing defects consisting of omissions and distortions of letters; defective memory; discrepancies in relating facts of life; inability to perform quickly and accurately simple problems of addition and subtraction in mental arithmetic. Knee jerks may be normal or overactive or underactive. The mood may be apathetic, depressed or euphoric; other psychiatric symptoms may be of a schizophrenic or neurasthenic type.

(2) *Meningo-vascular or cerebrospinal syphilis.*—The prominent diagnostic signs and symptoms are headaches, history of mood changes or convulsions, varying deep and superficial reflexes, pupillary changes, ptosis, ocular palsies, and facial paresis. The mental state is normal, dull or apathetic. Motor weakness may occur on one side of the body or in one extremity.

(3) *Tabes dorsalis (locomotor ataxia).*—Look for unequal, irregular or sluggishly reacting pupils, or Argyll-Robertson pupil; absent knee jerks; positive Romberg; ataxic gait, especially when the eyes are closed; hypotonia; and anesthetic areas of the skin. The history, usually of slow progression, may show failing sexual power or sphincter disturbances and pains in the legs or back, usually an irregular series of short, identical attacks of pain coming at intervals.

b. The epilepsies.—Look for deep scars on tongue, face and head. Since no physical findings are pathognomonic, it is necessary to discover if the individual has had

spells of unconsciousness, convulsions, "fits," "falling out" spells, "lapses," "dizziness," or "fainting." The individual should be disqualified on a verified history of such spells or of multiple attacks of loss of consciousness especially with incontinence or twitching or of frequent momentary episodes of being dazed, or of uncontrollable outbursts of rage or irrational conduct, or fugues, or treatment with anticonvulsive drugs over a long period of time. Such a history should be verified, if practicable, by a confirmatory medical record from a trustworthy source. *When a registrant is rejected for epilepsy a statement will be made by the examining board giving the basis for the diagnosis. In the absence of stigmata or a verified history and diagnosis is based wholly on the registrant's statement, it will be so stated.*

c. Paralysis agitans.—Paralysis agitans is recognized by frozen facies, unwinking stare, rigidity of the muscles, stooped posture, slowness of movement, tremors, slow, monotonous speech, etc. It may be unilateral. A history of encephalitis or influenza is obtained in only about one-half of the cases. Even mild manifestations disqualify.

d. Athetosis, dystonia, torticollis, chronic chorea.—These are names given to various types of irregular, intermittent involuntary movements, affecting various parts of the body, often associated with evidence of spastic paralysis. Simulation is possible and in doubtful cases previous medical records should be sought. Even mild manifestations disqualify.

e. Post-traumatic cerebral syndrome.—A history of head injury followed by headache, dizziness, loss of initiative or change of personality is suggestive; but independent confirmation of such alterations should be sought if possible. A dull apathetic expression, slight nystagmus, fine tremors, vasomotor changes, abnormal sweating, etc., are confirmatory evidence. If the syndrome is definite, even though mild, the individual should be rejected. The presence of signs indicating a focal lesion, even though mild, is also cause for rejection.

f. Multiple sclerosis.—A history of transitory weakness, numbness, ataxia of one or more extremities, transient diplopia, scotomata or bladder disturbances should arouse a suspicion of multiple sclerosis. The presence of optic atrophy, scotomata, definite nystagmus, corneal hypesthesia, absence or irregularity of abdominal jerks, exaggerated deep reflexes, a Babinski or similar signs, or ataxia and euphoria are common manifestations.

g. Muscular dystrophies.—There is atrophy of the muscles in some forms, hypertrophy in others, and, in general, decrease or loss of muscle power. In the pseudohypertrophic form some muscles are atrophied, others hypertrophied. In myasthenia gravis there is rapid fatigue of muscle power, appearing first in the facial and extrinsic eye muscles and later becoming generalized.

h. Chronic neuralgias.—A history of severe constant or recurrent pain, confirmed to the area of distribution of a single nerve or segment, without objective changes, suggests this diagnosis. Clearly defined entities are sciatic and trigeminal neuralgias. Less common are suboccipital, brachial and glossopharyngeal neuralgias. Neuralgias of other nerves are extremely rare and the diagnosis should be made with extreme caution. Neuritis, arthritis, bursitis, sinusitis, etc., and also hysteria and malingering must be considered in differential diagnosis. Evidence of previous treatment and the injection of procaine into the nerve presumably affected are important diagnostic aids.

i. Multiple neuritis.—This may be associated with the dietary deficiencies, infection or intoxication. The symptoms depend upon the cause and duration. They consist of pain, various combinations of diminution or loss of motor power most marked in the distal part of the extremities, sensory diminution or loss, tenderness of the muscles and nerves, loss or diminution of reflexes.

j. Cerebral vascular accidents.—Characteristically, the onset is acute, with or without unconsciousness. Almost any focal disturbance may result. Evidence of peripheral arterial disease may be inconspicuous. The diagnosis disqualifies.

Section XX
PSYCHOSES, PSYCHONEUROSES, PERSONALITY DISORDERS

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87. General considerations.—The detection of disorders of the personality is often most difficult and the general fitness of the individual for military life should be considered at the end of the medical investigation. At the time of examination there may be no obvious defects such as present themselves in other pathological conditions. Each examiner should constantly be on the alert throughout his contact with the individual to detect any sign of such disorders and should promptly report suspicious symptoms he may note to the chief examiner. (See par. 2*b*.) Every effort must be made to reject the mentally deficient and those showing evidence of nervous instability. The mentally deficient and unstable are always a detriment to the Army from the day they are accepted until they are separated from the service. Such men should under no circumstances be accepted.

88. Routine procedure.—*a*. The diagnosis of most psychiatric disorders depends in the first place upon the examiner's estimate of the person's behavior and response to the situation of the examination and in the second place upon an adequate history, supplemented if necessary by information gathered from the individual's own physician, courts, hospitals, social service or welfare agencies, etc.

b. Routinely, examiners should be on the watch for any of the following personality deviations: inability to understand and execute commands promptly and adequately, abnormal negativistic attitude, abnormal anxiety, silly inappropriate laughter, instability, seclusiveness, sulkiness, sluggishness, discontent, lonesomeness, depression, shyness, suspicion, overboisterousness, timidity, personal uncleanliness, stupidity, dullness, resentfulness to discipline, a history of nocturnal incontinence, sleeplessness, lack of initiative and ambition, sleep-walking, recognized queerness, suicidal tendencies either bona fide or feigned, and homosexual proclivities.

c. Abnormal autonomic responses (fainting, blushing, excessive sweating, shivering or gooseflesh, excessive pallor or cyanosis of the extremities) are also occasionally significant. Note also the lack of such normal anxiety or autonomic responses as might reasonably be expected under the circumstances.

89. Minimum psychiatric examination.—*a*. Mental and personality difficulties are most clearly revealed in the subject's behavior toward those with whom he feels relatively at ease. The most successful approach is often one of straightforward professional inquiry coupled with real respect for the individual's personality and due consideration for his feelings—which does not mean diffidence.

b. The psychiatric examination should be made outside of easy hearing of other men. Matter of diagnostic significance is often concealed when the individual feels that he must be impersonal and give replies that will not impress listeners with his peculiarity.

c. Questioning should begin with something that is obviously relevant to the immediate situation. One tries to elicit the difficulties which the individual has been experiencing in his relations with others and himself in his work and in his spare time activities. The examiner pays close attention to content and implication of everything said and to any other clues and, in a matter-of-fact manner, follows up whatever is not self-evidently commonplace.

d. The probable presence of some types of psychiatric disorders—in particular the major psychoses and marked degrees of feeble-mindedness—may often be suspected by alert observation of the individual's behavior if the examiner knows what to look for and what to regard as significant. In other cases one would not be able to suspect the presence of any morbid condition without some knowledge of the individual's history.

90. Class 1–A.—*a.* The range of personalities usually classed as "normal." Evidence of ability to get along tolerably with family, friends, casual acquaintances, authorities in school or society, employers and fellow workers. Conventional attitude toward sexual problems. Sufficient intelligence to graduate from grammar school unless prevented by external circumstances. Sufficient stability and ability to obtain and keep, or at least to seek, a job.

b. Marginal intelligence, if compensated for by better than average stability.

c. Men whose speech can readily be understood, even though there is a moderate degree of stuttering or stammering, if otherwise physically, intellectually and emotionally fit.

91. Class 1–B.—*a.* Moderate degrees of compulsiveness or obsessiveness.

b. Stuttering and stammering of a degree disqualifying for general military service but which has not prevented the man from successfully following a useful vocation in civil life.

92. Class 4.—Individuals who are found to have any serious mental or neurological disorder such as—

a. Mental deficiency.

b. Psychopathic personality.

c. Major abnormalities of mood.

d. Psychoneurotic disorder.

e. Pre-psychotic, post-psychotic and schizophrenic personalities.

f. Chronic alcoholism and drug addiction.

g. Syphilis of the central nervous system. (See par. 85*a.*)

h. Sexual perversions.

i. Stammering to such a degree that the registrant is unable to express himself clearly or to repeat commands.

93. Diagnostic criteria.—*a. Mental defect or deficiency.*—(1) Manifested by lack of general information concerning native environment; inability to learn, to reason, to calculate, to plan, to construct, to compare weights, etc.; defect in judgment, foresight, language, output of effort; suggestibility, untidiness, lack of personal cleanliness, anatomical stigmata of degeneration, muscular awkwardness. History of school life, vocational career, and disciplinary report will assist materially; then classify according to psychometric standards.

(2) Examiners will use extreme care and judgment in reporting their findings on enlistment records. Such terms as "imbecile" and "moron" will not be used, but an approximate psychometric scaling will be listed as cause for rejection, as "mental age, eight years." Elaborate psychometric estimation is not necessary and any accepted abbreviated method will suffice. Intelligence cannot be definitely estimated and there is no test that is infallible. They are all only approximations and must be evaluated only in conjunction with accompanying factors and circumstances. Illiteracy per se is not to be classified as mental deficiency.

b. Psychopathic personalities.—In this ill-defined, more or less heterogeneous group are placed those individuals who, although not suffering from a congenital defect in the intellectual sphere, do manifest a definite defect in their ability to profit by experience. They are unable to proceed through life with any definite pattern of standardized activity. They are unable to respond in an adult social manner to the demands of honesty, truthfulness, decency, and consideration of their fellow associates. They are emotionally unstable, not to be depended upon; act impulsively with poor judgment;

are always in difficulties, have many and various schemes without logical basis, lack tenacity of purpose, are easily influenced and oftentimes in conflict with the law. They do not take kindly to regimentation and are continually at variance with those who attempt to indoctrinate them in the essentials of military discipline. Such an individual has a decided influence upon his fellow associates and the morale of his organization, for he will not conform himself to organized authority and he derives much satisfaction in cultivating insubordination in others. Quite frequently he presents a favorable impression, is neat in appearance, talks well, and is well mannered. However, under this veneer the real defect is evident by past irresponsiveness to social demands and lack of continuity of purpose. Among this general group are to be placed many homosexuals, grotesque and pathological liars, vagabonds, wanderers, the inadequate and emotionally unstable, petty offenders, swindlers, kleptomaniacs, pyromaniacs, alcoholics, and likewise those highly irritable and arrogant individuals, so-called pseudoquerulents, "guardhouse lawyers," who are forever critical of organized authority and imbued with feelings of abuse and lack of consideration by their fellow men. All such men should be excluded from the services as far as possible, both because of the difficulties which these symptoms themselves cause and because of the fact that such individuals ultimately may develop fullfledged psychotic states.

c. Major abnormalities of mood (affective psychoses, manic depressive psychosis).—Major abnormalities of mood are shown by episodes of unreasonable elation or depression which have tended to recur without obvious connection with events. People who are known to be so mercurial in their reactions that their judgment is seriously impaired during the up or down swing of their moods should be rejected. Individuals known to have received medical or nursing care because of a morbid excitement or a depression should be rejected.

d. Psychoneurotic disorders.—(1) *Symptoms.*—These conditions, often having no objective signs, may easily escape notice. Such individuals may show—

(*a*) Conversion symptoms such as hysterical fits, absences, trances, hysterical deafness, blindness or loss of voice; hysterical paralyses or anesthesias, and vasomotor disturbances such as sweating, palpitation and dizziness, and other dysfunctions of internal organs. In evaluating all of these conditions, the history of interference with progress in civil life is of utmost importance.

(*b*) Excessive concern with minor or imaginary bodily ailments as manifested by multiple vague complaints, multiple operations for obscure disorders, unusual fatigability, vague pains, pressure feelings, distorted head sensations, etc.

(*c*) Obsessions, compulsions, phobic manifestations such as specific terrors of harmless objects or situations, food phobias, dirt and germ phobias, inflexible rituals of behavior about food, sleeping, dressing, compulsive acts, tics, obsessional thoughts, obsessional indecision, etc.

(*d*) Emotional disturbances such as chronic depression, mild elation, irritability and chronic or episodic insanity.

(2) *Physical disorders which may furnish important clues to psychoneurotic disabilities.*—Neurotic tensions may be manifested not only by frank psychoneuroses and behavior difficulties but also by manifestations of a variety of physical disturbances and organic disease processes. Such conditions as peptic ulcer, pylorospasm, mucous colitis, spastic constipation, neurocirculatory asthenia, paroxysmal tachycardia, vascular hypertension and hypotension, Raynaud's disease, fainting, convulsions, somnambulism, narcolepsy, migraine, glaucoma, eczema, psoriasis, enuresis, cardiospasm, impotency, and asthenia may have important emotional components and may therefore furnish important clues to the neurotic aspects of the individual. The presence of such conditions, if not in themselves disqualifying, should always lead to further study. Look for a close relationship.

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e. Schizophrenic group.—(1) This category comprises the grave mental or personality handicaps. Pre-psychotic and postpsychotic personalities and those actually suffering a schizophrenic ("dementia praecox") mental disorder manifest their condition by obscurely motivated peculiarities of behavior and thought. Of these, the so-called deteriorated states are the most obvious. Here belong the numerous shiftless, untidy, perhaps morose, sometimes nomadic individuals, who have had what was regarded as quite a normal childhood. Somewhere between the ages of 12 and 25 they underwent a change, acute or insidious, with dilapidation of their social interests and the habits in which they had been trained. They may or may not have received treatment in hospitals for mental diseases.

(2) The paranoid personalities are another large division. These persons cling to fantastic beliefs in their overwhelming importance, and often feel that people are persecuting them or otherwise interfering with their career or well-being. Some of them believe that they are in communion with supernatural beings. Others believe that they are victims of plots, secret organizations, spy rings, or religious or fraternal groups. They are often plausible in supporting these delusions by clever misinterpretation of facts. Some of them are very evasive and skillful at concealing the pattern of their disorder. A morbid suspiciousness of anyone who takes an interest in them is frequent. They may become tense and hateful when interrogated. An attitude of unusual cautiousness or suspiciousness toward the examining physician or toward fellow individuals should suggest the possibility that the individual may be paranoid.

(3) The catatonic and prepsychotic states may present great difficulty in diagnosis. Perhaps the only sign of these conditions is the impression of queerness which the person makes on anyone who seeks to get acquainted with him. The actual oddities of behavior or thought may be subtle; it may be difficult, in retrospect, to point to any particular instances of the unusual. The most striking signs of these conditions may in fact come out in connection with the physical examination. The physician, at some state of the physical examination, may observe a peculiar reaction which upon questioning may awaken a suspicion of a prepsychotic state. These individuals frequently entertain unfounded convictions as to bodily peculiarities or disorders which they attribute to excessive sexual acts of one sort or another. These beliefs, sometimes hard to elicit, are often medically incredible and bizarre. Questioning them on intimate personal matters often leads to great embarrassment, confused speech, or actual blocking of thought—so that they do not know what to say. Get history of family life and of school, vocational, and personal career.

f. Chronic alcoholism and drug addiction.—(1) *Chronic alcoholism.*—An individual will be regarded as a chronic alcoholic if he habitually uses alcohol to the point of social or physical disablement, as evidenced by loss of job, repeated arrests, or hospital treatment because of alcoholism. Such a history, if obtained, should be verified. Look for suffused eyes, prominent superficial blood vessels of nose and cheek, flabby, bloated face, red or pale purplish discoloration of mucous membrane of pharynx and palate; muscular tremor in the protruded tongue and extended fingers, tremulous handwriting, emotionalism, prevarication, suspicion, auditory or visual hallucinations, persecutory ideas.

(2) *Drug addiction.*—An individual will be regarded as a drug addict if he is or has recently been a habitual user of any of the opium preparations, cocaine, or cannabis indica (marijuana). A history of arrests for narcotic law violation is important; recent needle marks are suggestive; discolorations along the line of blood vessels on the arms, or scars from needle abscesses on the arms, shoulders, buttocks, or thighs are very important evidence but are not always present. The condition of the pupils is not important in active addicts.

g. Syphilis of the central nervous system.—See paragraph 85*a*.

h. Sexual perversions.—Persons habitually or occasionally engaged in homosexual or other perverse sexual practices are unsuitable for military service and should be

excluded. Feminine bodily characteristics, effeminacy in dress or manner, or a patulous rectum are not consistently found in such persons, but where present should lead to careful psychiatric examination. If the individual admits or claims homosexuality or other sexual perversion, he should be referred to his local board for further psychiatric and social investigation. If an individual has a record as a pervert he should be rejected.

Section XXI
PURPOSELY CAUSED PHYSICAL DEFECTS

Paragraph
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94. Report of apparently purposely caused defects.—Whenever it shall appear to an examining physician that an individual is suffering from self-inflicted or purposely caused physical defects which under the standards of physical examination prescribed herein would render him disqualified for military service of any kind, a full statement of the facts and of the condition of the individual and of the examining physician's recommendation will be prepared and submitted to the Director of Selective Service.

Section XXII
MALINGERING

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95. Definition.—The malingerer is one whose complaints of bodily disorders and whose behavior or acts are in simulation of some physical or mental disease for the definite purpose of attaining a particular end which is more satisfactory to him or of seeking an escape from a fear-infested situation. Malingering is encountered in a number of situations but most frequently during the preliminary examinations and early training periods of military service. The simulation of neuroses and of physical disorders includes a wide variety of problems which must be differentiated from the ordinary neuroses as well as from physical illnesses; however, simulation is always in keeping with the extent of the knowledge possessed by the individual regarding the particular disorder from which he pretends to suffer and therefore constantly changes its methods and its maladies. A person gifted with histrionic talent and who has a considerable degree of knowledge and skill at his command may be able to simulate physical or mental conditions to such perfection that physicians may sometimes be deceived.

96. Differentiation.—*a*. For a disorder to be classed as true malingering, it must fulfill three conditions:

(1) That no obvious or frank disease or personality disorder is present.

(2) That the individual is consciously aware of what he is doing and of the motive responsible for his attitude.

(3) That he is fixed in carrying out a purpose to a preconceived result.

b. When confronted with a case of malingering the observer should try to ascertain how much of what constitutes the total picture is well acted drama and consciously done and how much is true in part and more or less unconscious. For practical purposes these reactions may be divided into the following:

(1) Malingering for the purpose of attaining a definite end by simulation of a

disease by one who has no past history of similar patterns of reaction but who is making an attempt to escape in an emergency (temporary reaction); one who feigns his symptoms as a bluff and hopes to get away with it.

(2) Malingering to the extent of exaggerating or "capitalizing" conditions or symptoms that are present for the purpose of avoiding service. This includes an enlargement on minor physical ailments or on relatively insignificant diseases, emphasizing mild personality problems or neuroses, and over-emphasis on symptoms of fatigue, etc.

(3) Malingering as a manifestation of psychopathic personality with a suggestion or definite history of previous psychopathic behavior. In intelligence the psychopath may be retarded, of average endowment, or superior but he is incapable of adjustment under ordinary life conditions. The ranks of psychopathic personality contain many persons having an irresistible tendency to alcoholism, drug addiction, sex perversion and criminality including numbers of cranks, extremists, eccentrics, hobos and queer social misfits.

(4) The psychoneurotic suffering with hysteria, who believes in the reality of a disability which on the surface appears to be a definite simulation, requires a special investigation. The confusion of hysteria with true malingering is not infrequently made by those who consider nearly all hysterics as malingerers with symptoms that could be controlled voluntarily. Some of these psychoneurotics exaggerate more or less unconsciously their symptoms to gain their ends, thus emphasizing the questions of how much is neurosis, how much is simulation and how much is associated with a change in personality.

(5) Malingering or reactions considered to be malingering may appear in those basically psychoneurotic, insecure and apprehensive, or physically ill as well as in those suffering from psychosis, epilepsy and organic brain disorders where there has been a definite change in personality. These reactions frequently confused with pure malingering may become much worse during investigation or attempted correction.

c. Among these five groups the typical members are readily distinguished but intermediate and doubtful cases which resist differentiation do occur. It should be kept in mind that it is even more difficult for a healthy person to feign disease than it is for a diseased person to simulate health and that a malingerer may be able to simulate and accentuate single symptoms but he is practically always unable to feign the entire picture of the disease he has selected and thus the expert can usually detect omissions, discrepancies and contradictions in the situation.

97. Feigned medical diseases.—*a.* The detection and management of malingerers simulating medical diseases depend upon the absence of positive findings in an individual who presents the general characteristics of the malingerer. There is especial need for the physical examination to be thorough in this group. Some of the cardiac cases at first regarded as malingerers may later be found to have mitral stenosis or bacterial endocarditis. Similarly, proper tests may show the existence of peptic ulcer in those suspected of feigning digestive abnormalities. The estimation of the reality of rheumatic pains is always a difficult matter.

b. Tachycardia and thyrotoxicosis may be temporarily induced by ingestion of drugs such as thyroid extract. Egg albumin or sugar may be added to urine. Canned milk may be utilized to simulate urethral discharge. Cantharides may be taken to cause albuminuria. Digitalis and strophanthus may be taken to cause abnormal heart findings. The skin may be irritated by various substances. Cathartics may be taken to bring about purging or to simulate a chronic diarrhea. An appearance of hemoptysis may be produced by adding blood, either human or that of animals, to the sputa. Sometimes merely coloring matter is added. Those who can vomit voluntarily what they swallow use the same means to create the appearance of hematemeses. Similarly, coloring matter may be added to the stools. Mechanical and chemical irritants may be used to cause inflammation about practically all the body orifices. Jaundice may be

simulated by taking picric acid. Artificial jaundice is recognized by demonstration of picric acid in the urine. Crutches, spectacles, trusses, strappings, etc., may be used to create appearance of disability.

98. Feigned surgical conditions.—Under this are included old scars and injuries of the bones, fractures, and orthopedic conditions. Men may have teeth extracted in an effort to evade military service. Others may shoot or cut off their fingers or toes, usually on the right side, to disqualify themselves for service. Some may put their hands under cars for this purpose. Retention of urine may be simulated. Substances may be injected under the skin to create abscesses. Crutches, braces, strappings, or trusses may be used to give the appearance of disability. Wounds are rarely self-inflicted when witnesses are present; consequently it is almost impossible to be certain of malingering in some cases.

99. Feigned nervous or mental illness.—*a. Psychosis.*—Rarely feigned by individuals and then usually a silly, foolish type. In case of doubt, hospital observation is necessary, with verification of past records. Mental deficiency is frequently feigned, especially by illiterates.

b. Pain and hyperesthesia.—The most frequent of all complaints. History inconsistent, ordinary indications of suffering absent. Absence of other symptoms usually accompanies types of pain of which complaint is made. Absence of objective evidence of localized pains. Note behavior when the registrant believes himself unobserved.

c. Anesthesia.—Complaint of anesthesia itself creates a suspicion of malingering as most patients with anesthesia are ignorant of it.

d. Epilepsy.—Men who have sustained head injury may claim fits. These complaints may be in reference to grand mal or petit mal. Petit mal attacks are spoken of as fainting attacks. In grand mal attacks there is loss of pupil response to light, knee jerks are lost, and the Babinski reflex may be present.

e. Hysteria.—Not feigned in itself but its existence creates confusion as to malingering. The question to be decided is whether the individual is too seriously affected with the neurosis to be useful as a soldier.

f. Stiff back.—Stiff back is a frequent symptom of hysteria in mobilization among selected men. In cases of this kind, organic diseases of the vertebrae can and should be excluded if necessary by X-ray.

102. Bed wetting.—Enuresis either real or simulated may be a frequent complaint among individuals for military service, but it is *not* a cause for unconditional rejection. Men claiming to be bed wetters may be placed in class 1–A, unless enuresis is substantiated by a physician's affidavit or other acceptable documentary evidence.

103. General considerations.—*a.* All men suspected of malingering should be immediately subjected to a thorough psychiatric survey which should include a careful history of their previous behavior and adjustment record and a complete physical, neurological and laboratory evaluation. Observation in hospital may be required. If simple genuine malingering exists, the man should be confronted with the situation and given time to reconsider his attitude. Those malingerers whose past record is not unfavorable and who are otherwise acceptable should not be rejected. Suspected malingerers found suffering from definite psychoneuroses and others in whom signs of mental disorders are detected should be rejected for military service.

b. Whenever it shall appear to an examining physician that an individual is endeavoring to escape service by malingering, if otherwise mentally and physically fit, he will be accepted.

APPENDIX C

Meeting of Neuropsychiatric Consultants, Office of The Surgeon General

21 April 1945

REPORT OF THE COMMITTEE ON PERSONNEL

Committee Members
Lieutenant Colonel Thom, Chairman
Colonel Porter
Doctor Zabriskie
Major Berlien
Captain McClung

The committee made the following recommendations:

1. That Service Commands make an effort to equalize medical officer personnel with patient load within their commands.
2. That the Service Command Consultants submit the names of officers who should be selected for early rotation and the names of officers who desire oversea service.
3. That in making reports of station visits, the consultants give a review of the neuropsychiatric personnel with their MOS [military occupational specialty] numbers and any recommended change in MOS.
4. That the consultants select candidates for MAC [Medical Administrative Corps] OCS [Officer Candidate School] from enlisted psychiatric social workers (SSN 263) within their commands.
5. That no key personnel be moved from a command without notification of the command headquarters.
6. That Service Command consultants select candidates for training at the School [School of Military Neuropsychiatry] from among officers who have returned from overseas and officers who are unfit for oversea service.

REPORT OF THE COMMITTEE ON HOSPITALIZATION

Committee Members
Colonel Bleckwenn, Chairman
Doctor Parsons
Lt. Colonel Brill
Lt. Colonel Dunn

Administrative Problems

1. Enforce administrative discharges in theaters. Avoid evacuation and medical channels.
2. Work-up of psychopaths *only*—return to duty. Send psychiatric report with recommendations to line officers for future reference.
3. Expedite transfer of patients interhospital by telegram to regulating officer and direct emergency transfer when permitted.
4. Eliminate abuse of channels for separation of individuals with diagnosis "Psychoneurosis."
   a. Differentiate between illness and attitude.
   b. Stop prostitution of professional judgment.

c. NP [Neuropsychiatric] Department not a CDD [certificate for disability discharge] mill.

5. Recommend fusion of [AR] 600–500–CDD Boards.

6. Recommend recovered acute psychotics to duty.

7. Recommend paroxysmal disorders (occasional attack) be retained on duty status.

8. Request clarification AR 615–368 on homosexuals.

9. Request reinstitution of AR 615–365 for special cases (recovered psychotics, etc., not fit for further duty).

10. Hold Service Command meeting for psychiatrists and psychologists when minutes of this meeting are made available.

CONVALESCENT HOSPITALS

1. Dearth of personnel.

2. Deficiency of supplies and equipment (acceptance of gifts and utilization).

3. Immediate organization of receiving center (initial screen helps NP group).

4. Set out sights at 50–60% return to duty of NP casualties.

5. NP Division should have own CDD, Disposition, 368, 369 Boards.

6. Establish necessary machinery geared up to process 50 dispositions per day (units with 2,000 NP patients).

7. Use of psychologists and social workers in group therapy.

8. Men should go to duty from NP Division without advanced reconditioning if marked for limited service.

REPORT OF THE COMMITTEE ON PREVENTIVE PSYCHIATRY

Committee Members

Lt. Colonel Smith, Chairman

Lt. Colonel Brosin

Doctor Gregg

Major Appel

The Committee concluded that the most effective means by which service command psychiatrists can prevent psychiatric disorders are as follows:

1. By formulating opinions and advising the command on matters of administrative policy and procedures which affect the mental health of military personnel. Top priority at present should be given to:

a. Ensuring that emphasis is being placed on providing adequate treatment at the dispensary level.

b. Ensuring that ineffectives who are primarily attitude or morale problems are handled administratively rather than disposed of through medical channels.

c. Ensuring that psychiatric opinion is available to command on the most effective means of handling redeployment, problems of classification, training, discipline, furloughs and providing incentive for effective behavior.

2. By education of military personnel in psychodynamics. Top priority at present should be given to:

a. Education of commissioned and noncommissioned officers in the psychiatric aspects of leadership.

b. Mental Hygiene instruction of enlisted men. Advice and criticism on techniques in public speaking should be given to psychiatrists who present the TB MED 21 type of information to enlisted men.

c. General medical officers—instruction in psychiatry.

d. Instruction of the public in the nature of the military psychiatric problem.

3. By collaborating in the formulation of information and orientation programs designed to influence attitudes and beliefs of military personnel. Top priority at present should be given to the content of programs planned for returnees during redeployment.

REPORT OF THE COMMITTEE ON REDEPLOYMENT

Committee Members
Lt. Colonel Barnacle, Chairman
Lt. Colonel Farrell
Dr. Strecker
Major Goldman

I and E [Information and Education] Division is working on this problem and has a large responsibility. However, it is recognized that there are medical and psychiatric implications. Therefore, the following recommendations are offered:

1. Prevent hospitalization if possible.
2. Full utilization should be made of consultation service and outpatient departments of hospitals where redeployment is located.
3. Strengthen existing neuropsychiatric personnel with overseas men, if possible, and establish new Consultation Services in those camps where none exist or utilize the Division Neuropsychiatrist in this capacity.
4. Orientation projects recommended:
   a. Movies.
   b. Modifying TB MED (12 and 21) or production of a new TB MED for psychiatrists and enlisted personnel and officers stressing the need for "continuing the job."
5. It is recommended that no psychiatric screening as such be utilized at Redeployment Camps. Advise that any physical examination to be done be made before furlough and that statement be signed by soldier prior to furlough. Cooperation of the line and medical officers needed. A psychiatrist should be available for consultation only as indicated above.
6. Free use of sick-in-quarters in lieu of hospitalization except where there are definite indications for special care.
7. Maintenance of unit identification in redeployment. Officers and men should remain with their old units.
8. That dispensary care be utilized in medicine and surgery in treating the redeployed men.
9. Consideration should be given to the education of the families of the men who are being redeployed.

REPORT OF THE COMMITTEE ON CONSULTATION SERVICES, CLINICAL PSYCHOLOGISTS AND PSYCHIATRIC SOCIAL WORKERS

Committee Members
Colonel Ebaugh, Chairman
Lt. Colonel Seidenfeld
Major Guttmacher
Captain Goldberg

A. Consultation Services

1. These units should be designated as "Consultation Services" throughout the Army.
2. The personnel in them should be based on the established trainee strength. There should be per 10,000 trainees:
   a. One psychiatrist.
   b. One clinical psychologist.
   c. Three social workers (SSN 263).
   d. Two personnel consultant assistants (SSN 289).
   e. Three clerks.
3. Functions of the Consultation Services are well formulated in the pending TB MED on Consultation Services.
4. It is recommended that the Replacement and School Command and the Office

of the Surgeon of the Army Ground Forces consider the advisability of assigning a psychiatrist to the staff of Replacement and School Command. The psychiatrist should have had experience on the staff of a Consultation Service.

5. Consultation Services should be established in redeployment centers. They should be preferably staffed by overseas personnel.

B. Clinical Psychologists

1. A goal of at least 200 commissioned psychologists should be established.

2. Consideration should be now given to the advisability of training selected enlisted men to prepare them to serve as assistant psychologists.

3. In installations where patients are receiving vocational guidance, as part of the treatment program, the interpretation of such counseling should be left to the direction of the psychiatrist and the psychologist rather than to separation counselors.

C. Psychiatric Social Workers

1. Every possible avenue should be explored to discover enlisted personnel who through civilian experience in correlated fields are capable of being trained as military psychiatric social worker assistants.

2. The commissioning of selected, well-qualified social workers is advocated.

3. The appointment of a commissioned psychiatric social worker to each Service Command Headquarters is recommended.

4. It is estimated that there should be two psychiatric social workers to every psychiatrist, for all types of installations where the latter are used.

5. Schools for the training of qualified and potential psychiatric social workers, already in the Army, should be promptly established.

6. It is recommended that the Service Command Neuropsychiatric Consultant, in cooperation with the Personnel Consultant of the Service Command, should exert his efforts to insure the full utilization of psychologists and social workers in their respective professional specialties.

REPORT OF THE COMMITTEE ON PROBLEMS OF THE MILITARY OFFENDER

Committee Members
Lt. Colonel Schroeder, Chairman
Lt. Colonel Bloomberg
Major Hilger
Captain O'Kelly

1. It is assumed that the basic philosophy of the Correction Division is:

a. Restoration to duty of as many men as possible.

b. Maintain the deterrent value of incarceration of offenders as it related to potential offenders in the population.

c. Protection of society as long as possible from those who cannot be rehabilitated and whose crimes consist of offenses against property and/or persons.

(Note: In carrying out the previously mentioned functions, punishment will not be considered as the primary aim of the Correction Division. This does not exclude the temporary needs for punishment for maintenance of discipline.)

2. Resocialization of military offenders constitutes the primary objective of Rehabilitation Centers.

3. Role of psychiatrists in Rehabilitation Center.

a. Primary function is diagnosis and treatment of the individual.

b. Since treatment involves manipulation of the environment, the psychiatrist should serve in a staff advisory capacity to aid in the proper modification of training program and doctrines.

c. He should be a member of the classification board.

4. Qualifications of staff personnel in Correction Centers:

a. The psychiatrist should have experience and/or training in penology, or at least related experience such as in criminal or juvenile court work.

b. The administrative and training staff should have experience and/or training in penology and this pertains especially to those serving on P and S [Psychiatry and Sociology] Boards.

c. It is advisable to have members of the P and S Board as members of the classification board and in fact a single board could cover the functions of both.

5. Psychiatric knowledge should be brought to bear on the problem of military offenders in the following order of decreasing importance:

a. AWOL [absent without leave] and other less serious violations.

b. Expert testimony when requested in court-martial cases.

c. Rehabilitation center psychiatry.

d. United States Disciplinary Barracks psychiatry.

6. Concurrence is given to the 12 points listed below as psychiatrically important in "The Conference on Rehabilitation of Military Prisoners," Fort Leavenworth, Kans., 14–16 November 1944. Specifically it is recommended that in testimony for the P and S Board a diagnostic label not be made but in lieu of such a diagnosis the individual under consideration should be stated to be "not deemed restorable on NP grounds" or "deemed restorable on NP grounds," followed by a pertinent statement as to the essential psychiatric and personality characteristics of the individual concerned.

a. Establish a classification board to plan and periodically review the rehabilitation program for each individual and the total rehabilitation program. Psychiatric evaluations should contribute to the board decisions.

b. P and S Board should contain complete records on each man, including the findings, claims, dispositions, recommendations, etc.

c. The practice of giving a diagnostic label should be discontinued.

d. Group psychotherapy should be fully utilized.

e. Special types of cases causing problems in detention should be the subject of special psychiatric investigation with a view of making general recommendations as to their care and disposition.

f. A scientific "Follow-up System" should be instituted to determine the degree of success or failure of our methods with cases returned to duty.

g. A manning guide should be prepared to include personnel assistants to the psychiatrist in detention centers.

h. Standards of qualification of all personnel working with prisoners should be formulated.

i. A training program should be instituted for personnel working with prisoners.

j. Means should be provided for the exchange of ideas, methods, and policies between psychiatrists and psychologists doing this work.

k. Technical libraries dealing with criminology, penology, psychology and mental hygiene should be provided.

l. Studies should be undertaken to determine and formulate methods of preventing military violations.

7. A TB MED should be prepared on the subject of psychiatric testimony in matters pertaining to legal responsibility.

APPENDIX D

Report of the Special Committee to the Secretary of War on Induction

21 SEPTEMBER 1943

Major General NORMAN T. KIRK, USA
The Surgeon General
Washington, D.C.
SIR:

Pursuant to authority granted by the General Staff the following were appointed special consultants to the Secretary of War for the purpose of serving on a committee to study the procedures currently followed at induction stations with particular reference to the subject of rejections for mental causes, and to make recommendations concerning possible improvement: Doctors Karl M. Bowman, Titus H. Harris, Frederick W. Parsons, Arthur H. Ruggles, Edward A. Strecker and Raymond W. Waggoner. Doctor Winfred Overholser, Superintendent of St. Elizabeths Hospital, was detailed by the Federal Security Agency to serve on the committee and Col. Roy D. Halloran, MC, of the Office of The Surgeon General was assigned to serve with the committee. The committee met in Washington on 31 August 1943 and elected Doctor Overholser chairman. Meetings were also held in Washington on 1 and 2 September and on 18, 19 and 20 September 1943. The necessary travel was authorized, and all possible facilities have been extended by the staff of The Surgeon General's Office in Washington and in the field. Inasmuch as the report was called for on or before 23 September, much work had to be compressed into a short period; had time permitted, more details might profitably have been studied.

Interviews with a number of officials who were able to cast light on certain aspects of the problem have been very helpful to the committee. In addition to Lt. Col. Malcolm J. Farrell and Lt. John W. Appel of the Division of Psychiatry in the Office of The Surgeon General, the following have been interviewed: Col. Richard H. Eanes, Executive Assistant to the Director of Selective Service; Col. Leonard Rowntree, Chief, Medical Division of Selective Service; Brig. Gen. Frank T. Hines, Administrator of Veterans Affairs; Hon. Paul V. McNutt, Manpower Commissioner; Maj. Harold C. Bingham, Personnel Division, Adjutant General's Office; Maj. Margaret C. Craighill, MC; Lt. Col. Esmond R. Long, MC; Capt. Harold Dorn, SnC, of the Statistical Division, Surgeon General's Office; and Lt. Col. Cornelius Gorman, MC, Physical Standards Branch. On 1 September the committee took advantage of the meeting of eight of the psychiatrists from replacement training centers who were meeting in the Office of The Surgeon General and had an opportunity to discuss with them the various psychiatric problems as found in the field. The committee was also fortunate at that time in hearing Capt. Herbert X. Spiegel, MC, recently returned from service as a battalion surgeon in North Africa.

In the field an attempt was made to gain an idea of the practices actually being followed at the induction station. Each member visited one or more stations, spending a large part of the time with the psychiatrist, being present during his examination of inductees and also discussing with him and with the senior medical officer the methods followed. The induction stations at thirty-five points widely scattered throughout the United States were visited as follows:

First Service Command—Boston, Mass.
Second Service Command—New York City, Albany, Buffalo, and Rochester, N.Y.; Camden and Newark, N.J.

Third Service Command—Baltimore, Md.; Philadelphia, Pa.; and Richmond, Va.
Military District of Washington—Fort Myer, Va.
Fourth Service Command—Forts Benning and McPherson, Ga.; Fort McClellan, Ala.; and Camp Croft, S.C.
Fifth Service Command—Columbus and Toledo, Ohio; Indianapolis, Ind.; and Huntington, W. Va.
Sixth Service Command—Detroit, Mich.; Milwaukee, Wis.; and Chicago, Ill.
Seventh Service Command—Fort Snelling, Minn.; and Omaha, Nebr.
Eighth Service Command—Shreveport, La.; Tulsa and Oklahoma City, Okla.; Lubbock, Dallas, San Antonio, and Houston, Tex.
Ninth Service Command—San Francisco, Sacramento, and Los Angeles, Calif.; and Salt Lake City, Utah.

In addition, three station hospitals, Fort Benning, Ga., Fort Custer, Mich., and Fort Benjamin Harrison, Ind.; six general hospitals, Valley Forge, Halloran, Billings, Brooke, Lawson, and Letterman; and the First, Second, Fourth, Fifth, Sixth, Seventh and Eighth Service Command Headquarters were visited.

It is hardly necessary at this late date to labor the point that psychiatric problems constitute perhaps the largest single group of medical problems in the present conflict. This can be readily demonstrated by statistics as well as by the experience of both medical and line officers. Detailed statistics are readily available in the Office of The Surgeon General; they are extensive and there is no need to quote them at length here. As a result of the painful experiences of World War I with psychiatric problems, a considerable amount of attention was given to the question of the psychiatric selection, conditioning and disposition of men from the time that the Selective Service Act was first discussed. Certain criteria of psychiatric and neurological acceptability were set up and the Army standards as contained in MR 1–9 were adopted after consultation with a committee of the National Research Council, as was the case with the various other sections of that pamphlet. Provisions for the mental examinations of registrants, both at the local board level and at the stage of induction were contemplated and extended plans were made in the early days of Selective Service for the indoctrination of the local boards and of the medical advisory boards, as well as of the examiners on Army induction boards regarding the type of disqualifying mental symptoms.

About January 1942 the primary selective function of the local boards regarding physical standards was to a great extent given up, with the result that an increased load was thrown upon the induction board. Inductees were presented to the induction boards without accompanying information concerning facts which perhaps would have been well known to the examining physician of a local board regarding the inductee's history, family, economic and social. An attempt was made in several areas, notably Connecticut, Maryland, and more recently in New York, as well as in a number of other states, to provide significant data for the benefit of the psychiatric examiners at the induction boards. At the present time a country-wide plan is being set up by the National Headquarters of the Selective Service System and Medical Circular No. 4, which will be published very soon, will prescribe a plan whereby this type of information may be made available. The importance to the psychiatric examiner of having at hand significant data of this sort cannot be overemphasized. In February, 1943, the Navy was obliged to draw candidates from the induction lines and accordingly Naval medical officers have since that time been assigned to the induction boards.

At the beginning of the Selective Service activities the Adjutant General's Department developed a classification procedure which has gradually widened to include not only tests of education as such, but tests of native intelligence. Rejection is authorized on the basis of failure to meet these tests and under existing regulations

the findings of the psychologist are reviewable only by the commanding officer of the induction station and not by the medical personnel. Since 15 June 1943 all inductees failing to meet the standards are classified for rejection under the heading of educational, whereas previously some of these men were charged to the medical examination as rejected for mental deficiency or for other mental reasons. It was originally planned to have each psychiatrist examine not more than fifty inductees per day. Psychiatric examination is time-consuming compared with many of the other examinations called for, and it has been found that justice cannot really be done to the psychiatric requirements if the psychiatrist is required to see more than fifty men per day. However, in many areas the scarcity of psychiatrists has made it impossible to observe this limitation; we have found stations at which one psychiatrist had to carry a daily load of three hundred (300) or more, and in several stations, particularly in the Eighth Service Command, no psychiatrist whatever was on duty.

The rate of rejections during World War I was approximately 21 per 1,000 or 2.1%. The figure has consistently been higher during the present conflict. For the months of June and July, 1943, the percentages of rejections for mental conditions, not including rejections by the psychologist, was 8.87% and for neurological conditions 1.36%, or a total of 10.23%. This figure represents the average for the entire country. There are, however, some remarkable fluctuations as between different stations. At Boise, Idaho, for example, the rate was 0.6% whereas at Oklahoma City it was 23%. Some of these inequalities are perhaps accounted for by the educational standards and the standards of intelligence of the population in the particular area. They are also attributable to the skill of the psychiatrists (or the lack of it) and to the extent to which the psychiatrist is aided in his judgment by a history of the registrant. The load thrown upon the individual psychiatrist makes much difference, a large load promoting carelessness and the development of routine habits often resulting in the acceptance of undesirable material. The physical conditions of examination differ but, in general, the circumstances under which the psychiatrist must operate are reasonably satisfactory.

One of the principal forms of mental disorder which is cause for rejection is the condition known as psychoneurosis. This is a mental condition which embraces a wide variety of symptoms, no one of which may be disabling but the sum total of which may interfere with the efficiency of the individual when he is living a life which makes relatively few demands upon his ability to adjust. Placed in an unusual situation or called upon to make an unusual adjustment, as is the case in Army camps or in combat, the symptoms may increase to the point of complete incapability for any useful work. In a substantial number of instances, resumption of a life relatively free from stress may bring about improvement in the condition. It should be borne in mind that psychoneurosis is the result of unconscious mechanisms beyond the control of the individual, that it is an illness, but that it does not constitute what is generally termed "insanity" and that it is frequently unrecognized by the casual observer. These men may be extremely useful persons in the community and yet a total loss from the military point of view, not only being unable when ill to fulfill their military duties, but having an undesirable effect on the morale of a group, occupying hospital space, and calling for the time and attention of others who must care for them. The rejection of men of this type is therefore beneficial to the Army and to civilian manpower. The demands of warfare today, by reason of speed, increased mechanization, the greater amount of individual responsibility, and the development of means of destruction and terrorization, are far more intense than in previous wars. They call for a high degree of adjustability on the part of the soldier and render comparison with the data of previous wars somewhat misleading.

In spite of the efforts to weed out initially those who are poor risks from a psychiatric point of view, the rate of psychiatric breakdown is substantial and has caused alarm in some circles. There were on 28 August 1943 in the psychiatric wards

of the hospitals of the Army over 16,600 patients, and during that week there were admitted to those wards approximately 5,000. The rate of admission for July 1943 per 1,000 strength per year in the continental United States was 40, whereas in 1917–1918 the rate was 30; in the overseas combat theaters the rate for the same period was 60 as compared with the 1917–1918 rate of 16.5. The rate of discharge on Certificate of Disability is higher than for any other single cause. For the first six months of this year such discharges for neuropsychiatric reasons constituted 41.9% of the total number. In addition, a large proportion of the men discharged on what is known as Section VIII are discharged fundamentally for psychiatric reasons which existed prior to their enlistment or induction, such as mental deficiency or psychopathic personality. This group constitutes about 13% of the total number separated from the service.

Statistics furnished by the Veterans Administration indicate that since the declaration of war 4,737 men have been admitted to Veterans hospitals for neuropsychiatric reasons. This constituted 34% of the total. Of this number 1,257 were admitted during June and it may be expected that the number will increase month by month. Of the total group admitted since December of 1941, 2,158 or very nearly one-half have been ruled to be non-service-connected. In other words, every one of these men has been found to be suffering from a psychiatric or neurological condition which existed prior to his induction. In some of these instances it is not questioned that the condition might have been recognized upon induction had more time been available, had a history been available or had the skill of the examiner been greater. Whatever the reason, an error of omission was made.

In our studies of the functioning of selective service as it pertains to the induction stations we have found some disharmony in the National Headquarters. It seems clear to us, from our personal interviews and from reports from the field, that Col. Richard H. Eanes, Executive Assistant to the Director, holds opinions, undoubtedly sincere, regarding the place of psychiatry in the selective process which are nevertheless at great variance with the officially accepted principles of the Army and of Selective Service. These opinions are so fixed that we doubt seriously whether the most efficient psychiatric procedure can be carried out while Colonel Eanes occupies an official position in Selective Service Headquarters.

The committee found that throughout the country there was considerable variation in the psychiatric rate. Along the Eastern seaboard where the supply of civilian psychiatrists is adequate the rejection rate at induction centers tends (with some fluctuation) to be about 10%. In sections of the country where trained civilian and military psychiatrists are not available the rejection rate is lower.

In considering the rejection rate for psychiatric reasons two questions seemed to merit special consideration of the committee. They are:

1. Is suitable military material being unjustifiably rejected?

2. Is the Army accepting individuals who will not render satisfactory service?

In answer to the first question the committee reports that its members have sat with examining physicians, civil and military. In no case did the members find that individuals were excluded without good reasons therefore. Observation on the second point indicates that where the psychiatric personnel was inadequate selectees who should be excluded were being inducted. It is the committee's opinion that the psychiatric rejection rate, far from being too high, is actually lower than is warranted by the facts of the situation.

The committee included in its study a consideration of the psychological test procedure at the induction station because of its overlapping with psychiatry. Maj. Harold C. Bingham of the Personnel Division, Adjutant General's Office, was interviewed by the committee and a general discussion of the methods employed in the psychological tests was held. Major Bingham gave his opinion of the validity of these tests.

While in the field the committee studied the actual procedures carried out in giving psychological tests, the degree of cooperation and interchange of opinions between psychologists and psychiatrists, and the opinions of both psychologists and psychiatrists as to any method of improving procedures. It should be noted that the psychological tests are carried out independently of all other examinations at the induction centers; that the commanding officer of the induction center is the only person with authority to review and overrule the findings of the psychologists; and that interpretation of these tests is too separated from the rest of the examination. In actual practice considerable variation was found in the amount of interchange of opinion which occurred between psychologists and psychiatrists. In some centers psychologists never referred problems to psychiatrists and vice versa. In other centers it was found that psychologists might ask the psychiatrists for special study in individual cases, and the psychiatrists in turn would refer cases back to the psychologists for further examination and study. In some centers it was also found that there might be a general discussion of an individual case in which both psychologists and psychiatrists participated, while in other centers this never occurred.

At most centers the physical examinations, including the psychiatric, are carried on even after inductees were rejected on psychological grounds, but a few isolated instances were found where no further examination was given after inductees were rejected by the psychological test.

Some variation was found in the procedure in giving psychological tests. Practically always, some preliminary psychological tests were given as the first tests, but there was variation at different centers. Some centers carried out the entire psychological study before the inductee went on for further examinations, while at other stations part of the psychological examination was given first and the inductee later returned for other psychological tests. This means that there was considerable variation in the psychological report which accompanied the inductee when he appeared before the psychiatrist. In some cases the final result of the psychological test was available to the psychiatrist, and in other cases it was not.

The problem of malingering was discussed with Major Bingham who stated that the psychologists were well aware of the possibility of an attempt at malingering and had specific instructions concerning procedures for detecting it. He stated, however, "The question of malingering is a mooted question on which there is a good deal of different opinion. Personally, I have always thought it a psychiatric problem. It has seemed to me that a prevailing definition of a malingerer is that there is something abnormal about him."

In view of the high psychiatric discharge rate among the members of the Women's Army Corps, the committee studied the problem of WAC induction. The psychiatric discharge rate of this group is very high, namely 44.7% of the total discharge rate, largely for psychoneuroses. Our investigation disclosed several important induction factors.

1. The upper age limit for WAC enlistment is fifty years which is the age epoch of very high incidence of neuropsychiatric disability in women.
2. Induction boards do not regard the examination of WAC enlistees as being as important as for male inductees; they often do not have sufficient psychiatric personnel or facilities to make adequate examinations and, in some stations, no psychiatric examination of Wacs has been made.
3. At some induction stations women civilian psychiatrists are being satisfactorily used in the examination of WAC enlistees.
4. The criteria for the diagnosis of psychoneurosis in women usually are not so clearly defined by induction boards as in males.

The committee's investigation disclosed that the Navy is now represented on induction boards and in some induction stations the ranking medical officer is a Navy medical

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officer. An overall study of the problem, as far as the Navy is concerned, indicates four categories of psychiatric patients:

1. The disabilities are obvious; they are usually detected at induction and account for 15% of all rejections in the induction centers.
2. A "questionable fit" group. Here further information and observation, and often trial duty, are needed. About 4% of all recruits are found to be unfit.
3. A "potentially unfit" group, not obvious. These men are apt to do fairly well for about six months, then a considerable number break under increased stress between the sixth and ninth month of service. This group is not separated from the service without hospitalization before survey. Approximately 30% of all medical discharges from the naval service each month constitutes the personnel of this group.
4. This group contains the men who are reasonably well integrated and who break only under greater than average stress—usually combat conditions. They are admitted to hospitals here and abroad and make up 6% of the monthly total of medical surveys for neuropsychiatric reasons.

The Navy stresses the usefulness of time and observation under actual training camp conditions and feels it has demonstrated its importance notably in groups 1 and 2. The psychiatric discharges from "boot" camps average about 4%. Usually 50% of the men are given the test of observation under actual training conditions and in a few training areas the proportion is as high as 90%.

CONCLUSIONS

Your committee finds that in the past too large a number of psychiatrically vulnerable men have been inducted into the armed forces only to become psychiatric casualties, many within two months of induction. These men have been of no service value and instead have been consumers of manpower in the service. We find that instead of being too high the overall psychiatric rejection rates are at the present time too low, as demonstrated by the number of cases in the psychiatric wards, at the psychiatric out-patient departments, and those being separated from the service through Section II, Section VIII, and otherwise.

Many of these vulnerable men can function in civilian work and make valuable contributions to the manpower supply whereas in service they promptly go on sick call or enter hospitals and thus add to the burden of care without having contributed anything of value to the armed forces. The psychiatric work at induction stations has improved in the past year, but there are still areas in the country where there are no psychiatrists to function, and in these areas neuropsychiatric cases are being taken into service in large numbers. A continuing rejection of the present 8% to 10% of neuropsychiatric cases, or even higher rates, should reduce the present high percentage of discharges for psychiatric reasons.

We find no evidence to support a belief that the evasion of service through malingering occurs in any considerable degree. We further believe that most evasion of service through malingering is confined primarily to those men who would not in any event make a satisfactory adjustment in the armed forces.

RECOMMENDATIONS

The committee respectfully recommends that the present procedure at the Armed Forces Induction Stations as concerns neuropsychiatry be continued, with the following modifications:

1. Wherever feasible, the psychiatrist be required to examine not more than fifty inductees per day.
2. That the psychiatric examination be the last examination in the line.

3. That the completed results of the psychological examination accompany the inductee when he is examined by the psychiatrist, and that consultations between the psychiatrists and psychologists be encouraged.

4. That the psychological examination be considered as contributory to the psychiatric examination, and that it be subject to medical review as are all other parts of the examination.

5. That every effort be made to provide trained psychiatrists for those induction stations which are now undermanned, especially in the Eighth Service Command.

6. That, so far as possible, Army psychiatrists be rotated in service between induction stations and the psychiatric wards of Army hospitals.

7. That privacy and quiet be provided so far as possible for the psychiatric examination.

8. That more frequent use be made in doubtful cases of the employment of special diagnostic techniques, such as the electroencephalograph, and wider application of the provision for three days' observation.

9. That the procedure for furnishing an adequate social and medical history as prescribed in the forthcoming Medical Circular 4, Selective Service System, be put into general use as promptly as possible.

10. That, in accord with present plans of the Surgeon General's Office, each Service Command be supplied at regular intervals with information showing the place of induction of men who have been discharged for disability, as a means of evaluating the efficiency of the screening process at the induction stations.

11. That the upper age limit of WAC enlistees be lowered to the present Army age of thirty-eight years; that a uniform examination procedure as employed in the psychiatric examination of male inductees be followed, and that an effort be made to secure the services of a larger number of qualified women civilian psychiatrists to make psychiatric examinations of WAC enlistees.

12. That a change be made in the assignment of the liaison officer between the Surgeon General's Office and Selective Service Headquarters.

13. That each service command be provided with a psychiatric consultant.

This report and recommendations represent a summary of a large amount of factual data collected by the various members. All of this information is available to your Office should it be desired. The Committee wishes to express its appreciation of the courtesies extended to it, and its readiness to be of further service should such service be of assistance to the War Department.

Respectfully yours,
WINFRED OVERHOLSER,
Chairman.
KARL M. BOWMAN,
TITUS H. HARRIS,
FREDERICK W. PARSONS,
ARTHUR H. RUGGLES,
EDWARD A. STRECKER,
RAYMOND W. WAGGONER,
R. D. HALLORAN,
Colonel, MC,
Chief, Neuropsychiatry Branch.

APPENDIX E

Neuropsychiatric Problem in the Army

An analysis of the extent of the neuropsychiatric problem in the Army and the recommended policy, plans, and procedures for diagnosis and treatment of military personnel with psychoneuroses are presented in the memorandums which follow:

MEMORANDUM FOR: Gen. Kirk through Gen. Hillman 15 JUNE 1944
SUBJECT : Extent of Neuropsychiatric Problems in the Army

I. INDUCTION.

a. Rejection rate.—The neuropsychiatric rate is higher than any other cause of rejection. During 1942 and 1943, 1,250,000 men (about 12 percent examined) were rejected because of mental and emotional abnormalities. This is equivalent to 104 divisions! During the last 6 months of 1943, 20 percent of the men examined were rejected for neuropsychiatric reasons.

(1) Possible causes (in addition to the recognized high incidence of neuropsychiatric disorders in civilian life):

(a) Attitude of the public toward war and Army service.

(b) Lack of motivation in selectees; i.e., the security of their home, friends, and job far outweighs their belief in their importance for and their need by the Armed Forces.

b. Neuropsychiatric examinations at induction centers are not satisfactory because of:

(1) Necessary speed and the consequent brevity of the examination.

(2) Insufficient historical data are available. Selective Service System Circular No. 4, dated 18 October 1943, recently inaugurated, is increasingly helpful as it becomes more widely used. The forms need review and probable modification.

(3) There is an inadequate number of neuropsychiatrists and too often these are mediocre in quality. The induction board examination is often regarded as having a low priority in the assignment of physicians.

(4) Clinical psychologists and psychiatric social workers, both of whom are probably available, could be of great help to the neuropsychiatrist but are not included in the table or organization.

(5) A directive recently issued will improve the situation by modifying the methods of examination and eliminating the necessity to formulate the diagnostic entity to label each rejectee.

c. Desirability for consideration of neuropsychiatric rejectees:

(1) The cause of rejection should be tactfully and adequately explained, although too often this is not done.

(2) Labeling a man with a psychiatric diagnosis stigmatizes him and often may affect subsequent employment.

(3) At present there are almost no organized educational efforts directed toward communities regarding the understanding of this class of rejectees.

II. INCIDENCE OF NEUROPSYCHIATRIC DISORDERS AND DISCHARGE RATES.

a. Admission rate.—The admission rate to our hospitals in continental United States for neuropsychiatric cases in 1943 amounted to 140,977—the equivalent of 12 divisions. This rate does not include any neuropsychiatric cases occurring in oversea

theaters or the large group of psychosomatic problems and cases labeled "exhaustion" and "operational fatigue." As of 1 May 1944 there were 15,700 neuropsychiatric patients in the Zone of Interior Army hospitals, one-third of whom were in locked wards.

b. Incidence rates.—The incidence of severe neuropsychiatric problems is reflected in the admission and discharge rates. The total neuropsychiatric CDD discharges from July to December 1943 were 96,178, which amounted to 8 divisions. The total neuropsychiatric CDD cases, plus Section VIII discharges, from July through December were 132,959, or the equivalent of 11 divisions. Approximately one-third of the patients evacuated during November and December 1943 from oversea theaters were neuropsychiatric cases. Apart from all these figures, one must consider the large number of patients seen in the outpatient departments of hospitals and never admitted to the hospitals and consequently not discharged. To these must be added the same group of patients seen by the division and replacement training center neuropsychiatrists. The large number of "battle exhaustion" and "operational fatigue" patients are not included in any available figures. A fairly large percentage of patients on orthopedic, gastrointestinal, and cardiovascular wards are primarily neuropsychiatric cases. Every severe traumatic patient, such as the amputee, has important psychiatric aspects.

c. Causes.—There are many contributing and interrelated causes. The following specific influences in the production of these high rates are worthy of consideration for possible corrective measures.

(1) Failure of command function in providing good leadership. There is abundant evidence to indicate that where there is good leadership, neuropsychiatric casualty rates (including combat) are lower. With poor leadership the rates are higher.

(2) Lack of motivation. Efforts to date have failed to educate large masses of men as to why we fight.

(3) Misassignment in jobs, as well as in location. (Even the medical recommendation that the man be kept in the Zone of Interior is often ignored.)

(4) No available assignment; i.e., men who are good only for labor, and with no labor units in existence, they are given assignments beyond their capacity.

(5) Evidence suggests that training methods may provoke psychoneurotic responses.

(6) Individualism of our culture has developed an intolerance to the regimentation and discipline essential to the Army.

(7) With the combination of inadequate motivation and misassignment, the neurotic symptomatology becomes, in some instances, a sought-after vehicle for exit from the Army. Thus, psychoneurosis may become not only acceptable to such men but even attractive. The solution is not in stopping *all* discharges (which would only clutter our efforts with noneffectives) but in correcting causes.

(8) The high frequency of psychoneurotic adjustment in civilian life *is* recognized but it is not recognized that adjustment for the neurotic within the Army is far more difficult than in civilian life. The soldier is either on duty or, of necessity, a casualty under medical care. The neurotic civilian can so modify his life that he may work and does not become a medical problem.

(9) Need for simpler administrative discharge for mental deficiency, inaptitude, and defects existing prior to induction.

(10) There must be fundamental recognition that the Army, and particularly the Medical Department, cannot *cure* severe psychoneurotic patients within the structure of the Army. At most we can slightly modify them but their effectiveness will depend upon our ability to utilize men of limited capacity. On the other hand, the majority of severe "battle" reactions can be readjusted if treated early and adequately.

III. TREATMENT AND REHABILITATION EFFORTS.

a. Attitude and policy toward psychoneurotic (and psychotic) patients:

(1) Prompt disposition of unsalvageable men is clearly the sound course but

the Army's position as to this has varied from one extreme to the other. War Department Circular No. 161, dated 25 April 1944, caused the discharge of thousands of usable men. On the other hand, War Department Circular No. 293, dated 11 November 1943, has resulted in such pressure on commanding officers that there is evidence that an increasingly large number of ineffectual men are being retained, although undoubtedly this circular has been the cause of retaining many usable men who would otherwise have been discharged. Unsalvageable personnel improperly retained because of misinterpretation of this circular or pressure resulting from it have in turn added greatly to the problem of adequate and appropriate job assignment.

(2) Until recently treatment of neuropsychiatric cases has been of secondary consideration because of the attitude that all such cases should be discharged as rapidly as possible. More recently, because of the need to salvage men, the Medical Department is placing much more importance upon treatment (TB MED 28, dated 1 April 1944).

(3) Individuals classified as having a constitutional psychopathic state have generally been discharged without effort at treatment. These make up a considerable portion of the Section VIII cases and discharges for this cause in the last 6 months of 1943 equaled the strength of 3 divisions. While this group has a smaller percentage of salvageability than the neuropsychiatric group previously mentioned, no serious effort whatever has been made at salvage. In view of the shortage of manpower and because certain of this group can certainly be salvaged with proper treatment, it would seem that some test effort, at least, should be made along these lines.

b. Personnel: Medical.—To even meet the requirements as set forth by tables of organization for hospital units, approximately 500 neuropsychiatrists will be needed wtihin the next 8 months. To meet this need, 140 recently graduated medical students are being given a 3 months' course in neurology and psychiatry, to be completed about 8 July 1944. It is not expected that more than 25 additional civilian neuropsychiatrists will be entering the Army during this period. At least one additional course, and preferably two courses, should be projected for the coming year.

Nonmedical.—Psychologists are now slowly being made available through The Adjutant General's Office, to be commissioned in that department and assigned as assistants to the neuropsychiatrists in hospitals and consultation services in replacement training centers. They have tentatively been included in the table of organization for overseas general hospitals and all hospitals of over one thousand beds in the Zone of Interior. It is estimated that between 250 and 300 such men will be necessary, although at present there are only about 75 available.

Psychiatric social workers can be of major help to the neuropsychiatrist at induction centers and replacement training centers and in hospitals, and will be of much use in the neuropsychiatric section of the reconditioning unit. Probably hundreds of these are in the Army. However, the Neuropsychiatry Division knows the names of only 325, and these names are located through the records of a civilian agency. Of these only about 60 are at present in clinical work, and there seems to be no simple machinery by which the others can be promptly freed from their present assignments to do this work for which they are specially qualified. The numbers of such trained persons required are so nominal that their loss could not noticeably interfere with the other work of the Army, whereas their special training is badly needed to meet the acute psychiatric problem which the Army faces.

c. Methods.—Treatment, preventive or reconstructive or both, is being carried out with varying degrees of success by the following agencies:

(1) Hospitals. TB MED 28, dated 1 April 1944, will improve the methods but psychoneurotic patients should, as a general policy, be removed from hospital wards and placed in special facilities annexed to hospitals as a part of reconditioning units. A directive to accomplish this is now in press.

(2) The division neuropsychiatrist. Most reports indicate that very satisfactory work is being done by the sixty division neuropsychiatrists but their work should be coordinated by the appointment of a psychiatrist to each army (two have been so appointed) and arrangements should be made so that there can be a direct route of technical communication between the Neuropsychiatry Division of The Surgeon General's Office and these men. The division neuropsychiatrists also are badly in need of enlisted men as assistants but are now, as a general matter, prevented from obtaining these because there is no allotment for them under the existing table of organization of the division.

(3) The replacement training center neuropsychiatrist. Neuropsychiatrists at 30 Army Service Forces training centers are now doing an excellent job but similarly need a table of organization to include a psychiatric social worker for every two to three thousand men served by the unit.

(4) Outpatient departments. In connection with hospitals, outpatient departments are doing excellent work but would be greatly facilitated by the addition of a psychologist and an adequate number of psychiatric social workers.

(5) Neuropsychiatric sections of reconditioning units. With only a very few exceptions, these are still merely projects on paper but they offer the most hope of providing effective psychiatric treatment. The program for these is outlined in TB MED 28, dated 1 April 1944, corrected in TB MED 32, dated 15 April 1944.

(6) Retraining. Three experimental units caring for approximately 1,200 men at the Engineer Replacement Training Center, Fort Belvoir, Va., the Quartermaster Replacement Training Center, Camp Lee, Va., and the Ordnance Replacement Training Center, Aberdeen Proving Ground, Md., have been eminently successful and should be extended to all Army Service Forces training centers and selected Army Ground Forces training centers. The opportunity for job placement in the latter is much less than in the former. A weak link in the rehabilitation of neuropsychiatric patients is the lack of assurance that men will be assigned with some consideration of their choice, condition, and ability, although this is specifically directed in WD Circular No. 293, dated 11 November 1943, and reinforced by WD Circular No. 164, dated 26 April 1944. In cooperation with the Neuropsychiatry Division of The Surgeon General's Office, Dr. Walter V. Bingham of The Adjutant General's Office is drawing up an additional directive, specifying psychoneurotic patients, to aid in this direction.

d. Discharge.—The principle holds that the earlier treatment is given, the more likely it is to be successful. Once the neuropsychiatric patient crosses the discharge line, he has a fair chance of being a Government pensioner indefinitely. In the last war it is estimated that each hospitalized neuropsychiatric casualty cost us $33,000. Every discharged neuropsychiatric patient with a diagnosis of "psychoneurosis, severe," begins with a minimum of $50 a month pension and, literally, is paid to remain sick. In addition, he is stigmatized and in many places is refused jobs.

Discharge procedure probably needs reconsideration as applied to the neuropsychiatric case. Oversea veterans return in many instances disgruntled, disillusioned, and embittered and, if discharged, not only may remain invalids or semi-invalids but convey their attitudes of hostility to their relatives and friends. There is inadequate preparation of the men for discharge and inadequate preparation of the community and families for their acceptance. There is very limited provision for outpatients in civilian psychiatric clinics. Of an available 39,417 Veterans' Administration hospital beds for neuropsychiatric patients, 37,275 are now occupied, with a turnover of about 1,000 closed-ward cases per month. These beds, however, are presumably entirely for psychotic patients. There are essentially no outpatient facilities provided by the Veterans' Administration for neuropsychiatric cases. Although the neuropsychiatric problem in the Army is one of its chief concerns and the same holds true for the Veterans' Administration, there is no official advisory relationship between the neuropsychiatric divisions of these two organizations.

IV. PREVENTIVE PSYCHIATRY.

The major job of psychiatry in the Army, as conceived by the Neuropsychiatry Division of The Surgeon General's Office, is the psychiatry of the normal man—the preservation of his mental health. Selection and treatment are extremely important but most important are the motivation and the placement of each individual soldier. The normal living habits and attitudes of the average American civilian are antithetical to what must be demanded of him in the Army in the way of regimentation, discipline, and rigorous existence. His adjustment to the various features of the training program, to the prolonged separation from home, to the necessary isolation and often indefinite waiting, and to battle experiences produces far more severe psychological strains than any other comparable event in civilian existence. Any man may break and it is widely recognized that the majority who do break in combat could not have been screened out by any psychiatric or psychological technique.

a. Morale.—While the Morale Services Division is doing an excellent job, this job is still inadequate as evidenced by surveys and many reports indicate that the masses of men have no clear conception as to why they fight. Because they are very much influenced by the home situation and particularly the letters from their families, it would seem desirable to take the initiative by radio, press, and cinema to orient the civilian population. There is a direct relationship between the state of morale among the troops and the number of neuropsychiatric casualties. This suggests that a much more influential and powerful liaison should be established between the Neuropsychiatry Division of The Surgeon General's Office and the Morale Services Division.

b. Leadership.—A more adequate understanding of psychiatric and mental hygiene principles should be given line officers. TB MED 12, dated 22 February 1944, outlines these but has "no teeth." The inclusion of these lectures in organized courses is more or less optional and probably no provision is made for their utilization in our vast Army overseas. It is felt that one of the important causes of the development of neuropsychiatric conditions is the lack of adequate leadership. This applies to officers in all ranks, commissioned and noncommissioned, who have charge of troops. A problem here is the rigidity of the system, which tends to prevent a sufficiently facile reclassification or readjustment to a responsibility commensurate with the capability of the individual. In this connection it should be emphasized that noncommissioned officers are key personnel and that their appointment should be made with the greatest care and their training include a considerable amount of direction in the handling of men. It is felt that the present system of casual or superficial selection of noncommissioned officers without thorough examination of their records or capabilities needs remedial attention.

c. Public relations.—Because of the extent of the neuropsychiatric problems and thier effect upon the morale of the soldier as well as of the home front, a policy of absolute frankness should prevail, with all facts and figures regarding this subject given out only after check by The Surgeon General's Office. Because of the magnitude of the problem, consideration could advisedly be given to the appointment of a press representative within the Army, oriented to psychiatry, who could devote himself to aggressive leadership in formulating civilian attitudes and better understanding. The Neuropsychiatry Division was, until recently, greatly handicapped in giving out any information even to scientific groups about this field. This has now been partially corrected but we are still not permitted to give out any figures. It is felt that certain figures could be given out which would serve to furnish the public a much more accurate picture of the situation and avert suspicion of the Army, at the same time not causing any violation of any security protection.

V. POSSIBLE RAMIFICATIONS OF NEUROPSYCHIATRY.

The field of neuropsychiatry embraces a study of the motives, attitudes, and

behavior of individuals. As it concerns the Army it, of necessity, should include major activities within the Army. It can, however, present only a point of view, make suggestions, or possibly offer advice regarding motives, attitudes, and behavior. The following suggestions are made on the assumption that contributions of neuropsychiatry might be valuable to these particular endeavors.

a. Classification.—Entirely upon the basis of medical experience, the following defects are apparent in our present classification system:

(1) A large percentage of the neuropsychiatric casualties seen are related to misassignment.

(2) There is insufficient flexibility in reassignment and no assurance that a man trained for a particular job can be held in that job.

(3) There is a lack of adequate liaison between the Medical Department and the classification officers. WD Circular No. 100, dated 9 March 1944, is a step in this direction but there are many reports that this advice is ignored.

(4) The method of using a group of men to fill an allotment more or less regardless of their capacities is perhaps often necessary but it explains many of the misassignments. Further, when replacements are sent, apparently insufficient attention is paid to the different rates of mortality and casualties within specialized types of work so that many men are assigned to types of duty quite different from those intended for them.

(5) Oversea replacements are too often inadequately trained recruits from replacement training centers. They have never been a "part" of an organized unit but know they are going into combat.

(6) The present classification system is based largely upon the man's experience and with minimal regard for his choice and with too little critical evaluation of his personality equipment.

b. Training.—It seems probable that certain defects of a psychiatric nature exist in our training organization and methods, which might advisedly be given consideration. Specifically, the replacement training center receives our recruits and, in most instances, is less capable, because of its temporary structure, to provide aids in adjustment of the men to new conditions than most other organizations or units within the Army. The officers and noncommissioned officers know that the recruit is assigned to them for only a limited period and there is no unit to which the individual can give his allegiance or with which he can make any permanent identification. Obviously, substitutive opportunities must be provided.

Training could be more effectively given if the troops were more carefully graded psychologically as to their capacity to learn. This would entail the establishment of labor battalions, which have proved so effective in the utilization of manpower in the British Army and which certainly, to date, have reduced their neuropsychiatric discharge rate.

The training methods in certain camps might be given consideration, although it is recognized that certain methods are excellently carried out in one camp and poorly in another, depending upon the personal equation of the leadership. Consideration for effective teaching of the men and for their physical comfort is sometimes disregarded, despite instructions to the contrary. Too often their chief motivation is fear, and stress is laid upon the destructive possibilities rather than the constructive opportunities. Certain specific methods, such as desensitization to explosions and infiltration courses are, in some instances, disturbing experiences rather than desensitizing.

The Neuropsychiatry Division is attempting to formulate, through the neuropsychiatrists in replacement training centers, some constructive suggestions regarding training methods, to be the basis of consideration for possibly a more detailed survey of this field. A recommendation concerning the formation of labor battalions has been forwarded, through the Training Division of the Army Service Forces, to G–1.

Superficial impressions gained, to date, relative to training include the failure

to make sufficient use of TB MED 12 and TB MED 21 (lectures on mental hygiene to officers and enlisted men); too frequent utilization of fear as the chief stimulus to learn; lack of adequate provision for training and the consequent usage of dullards and slow learners; lack of full appreciation of officers of their leadership responsibility, particularly to new recruits; and the overemphasis on competition in qualifying for marksmanship.

c. Selection.—Our most conspicuous psychiatric flaw relative to selection is concerned with officers. Except for those few who came into the Army by way of the draft, officers are not given a personality evaluation or psychiatric study. The British have been eminently successful in this field and now have established officer selection boards, including a psychiatric study, throughout the entire Empire. One indication of the seriousness of this failure to have psychiatric studies of officer candidates is the fact that between 45 and 55 percent of all officer retirements are because of neuropsychiatric difficulties. This figure, however, does not even remotely indicate the large number of officers who are failures in the command function of maintaining morale within their troops or who are otherwise inadequate as leaders. There is an increasing problem, with psychiatric ramifications, in the number of ineffectual high-ranking officers who are recognized as not being really adequate but yet not so grossly incompetent as to justify a reclassification. Consideration should be given to a more fluid status of ranks.

d. Motivation.—As indicated above, the motivation of the soldier to fight is not only a most significant factor in the achievement of victory but also determines the state of morale and mental health. There is a direct relation between the state of morale and the neuropsychiatric casualty rate and these are directly connected with the quality of the leadership.

Surveys have indicated that only two soldiers in five men believe they should be in the Army and many of them are fighting because the Army called upon them to fight and not because they feel threatened. Essentially such men are fighting for the Army and not for themselves, which implies an expected bargain—some sort of a return or reward for the servant.

To date we have failed, in varying degrees, in helping many soldiers appreciate that they are fighting for themselves; we have failed in some degree to make them feel that their efforts are appreciated; and we have failed to make the public fully aware of the need to fight this war. The latter is not the Army's responsibility but is essential to the Army's success.

Our Morale Services Division is making an excellent attempt to assist the command but the motivation must come directly from the command. Many reports indicate a lack of consideration for the individual, a lack of confidence on the part of the soldier in his officers, a lack of consideration in the form of privileges or concessions or evidences of personal interest in the soldier, a long line of broken promises, and petty restrictions. These are all of importance to the Neuropsychiatry Division because they produce neuropsychiatric casualties in direct proportion to their frequency and intensity.

It is believed that consideration might advisedly be given to a considerably enlarged Morale Services Division, with more direct contact with the command. Such a division should have a direct responsibility for civilian morale, since it is reflected in the soldier.

e. Demobilization and reconstruction.—As far as the neuropsychiatric casualties are concerned, there is no adequate organized program for their care after discharge. The Army will receive the blame for breaking them and, while the Veterans' Administration will care for the frankly psychotic, the psychoneurotic patients (comprising 75 percent of the discharges in this field) will have to shift for themselves with no planned education of the families or the community and no planned provision for

their further medical care. Under the present Veterans' Administration system, they will be pensioned and compensated to remain sick.

/s/ W. C. MENNINGER,
Colonel, MC.

MEMORANDUM FOR: The Assistant Chief of Staff, G–1. 10 NOVEMBER 1944
Through: The Commanding General, Army Service Forces.
Subject: Psychoneuroses.

1. This memorandum has been prepared in compliance with the request of The Assistant Chief of Staff, G–1, dated 12 October 1944, for full information on present policies, plans and procedures for the diagnoses and treatment of individuals with psychoneuroses.

2. *General.*

a. It should be understood that psychoneurosis constitutes only one type of neuropsychiatric disorder, which along with psychoses, psychopathic personalities, mental deficiency and neurological disorders, represents a major medical problem in civilian life as well as in the Army. From 15 to 30% of combat casualties are neuropsychiatric and over 90% of these are cases of psychoneurosis. 30 to 40% of cases evacuated from overseas theaters are neuropsychiatric and of these approximately 75% are psychoneurotics. Approximately 70% of the 219,000 men who have received medical discharges from the service because of neuropsychiatric disorders are cases of psychoneurosis.

b. Psychoneurosis is a sickness which always represents maladjustment of the individual to his situation. It may develop in a normal individual under severe stress or become evident in a less well organized individual under slight stress. The causes for the present high rate of psychoneurosis in military personnel are believed to be:

(1) Stress of military service, including danger, regimentation, separation from home, etc.

(2) Deficient motivation and incentive.

(3) Classification and job assignment.

(4) Unit leadership.

c. The retention and utilization of individuals with psychoneurosis has been determined by War Department policy which has varied from time to time depending upon the manpower needs. At one time all those with psychoneurosis were discharged for disability regardless of the extent of incapacity. At present those who are capable of performing any duty and for whom assignments are available are retained in the service. Those for whom no assignments are available may be discharged under the provisions of Section II or Section X, AR 615–360. The type of discharge is dependent upon the degree of incapacity.

3. *Diagnosis.*

a. *Policy.* The policy of this office is to confine the term, psychoneurosis, to those individuals who in professional medical judgment exhibit the signs and symptoms which satisfy the criteria for that diagnosis as established by generally accepted medical knowledge and practice.

(1) The criteria differ in no essential way from those customarily used in medical practice among other nations or in civilian practice.

(2) The mere existence of "nervousness," neurotic traits, attitudinal or motivational problems is *not* regarded as justifying the term, psychoneurosis.

(3) There is no evidence that a new clinical entity is occurring among military personnel which would justify introduction of a new diagnosis in medical terminology.

(4) It has been suggested that cases of psychoneurosis should be designated by other terms in the hope of escaping the stigma attached to psychoneurosis. This office is strongly opposed to such a policy. There is ample evidence as to the unwisdom

of employing euphemisms for well established medical entities. The difficulty is not with the term, but rather with the attitude toward and understanding of the term.

b. *Procedures.* Individuals may either report voluntarily to a medical station or be sent by their commanding officers because of ineffectiveness or evidence of disorders. Initial diagnosis is made by a medical officer who may or may not be a qualified psychiatrist. Before any individual is discharged from the Army for psychoneurosis, he must be studied in a hospital and his diagnosis confirmed by a board of medical officers, the majority of whom are not psychiatrists, in most instances. The board proceedings in turn are subject to review of higher authority. In addition, consultants in neuropsychiatry of high professional standing constantly inspect the diagnostic studies and the accuracy of this diagnosis in each service command.

c. There is nothing to indicate that the diagnosis of psychoneurosis is being misused generally. It is understandable that the term has received publicity because of the large number of cases which have been encountered and the widespread misunderstanding as to the meaning of the term.

4. *Treatment.* The present policy provides for the treatment of all individuals with psychoneurosis. This is in contrast to previous policy which provided for the disposition of cases without benefit of treatment. In spite of this change in policy, however, the emphasis which can be placed on treatment depends upon the current policy regarding disposition and utilization of individuals with psychoneurosis.

a. *Policy.* Treatment policy includes the following points:

(1) All cases of psychoneurosis will be treated. Those individuals to be discharged, however, will not be retained merely to receive maximum benefit of treatment except in the cases where the psychoneurosis has been incurred in combat.

(2) Each case will be regarded as a medical emergency requiring prompt treatment.

(3) Cases will be regarded as sick men needing medical treatment rather than disciplinary cases needing punishment or threats.

(4) Military discipline will be maintained.

(5) Treatment will be by or under the supervision of psychiatrists. Other personnel will be utilized including line officers, other medical officers, clinical psychologists, Red Cross, etc.

(6) Treatment facilities will be centralized in order to control policy and procedures and to compensate for the existing shortage of trained personnel.

(7) Patients will be segregated from nonpsychiatric cases in most instances.

(8) The majority of cases will be kept out of hospitals for treatment.

(9) Patients will be given a full time program including training, education, orientation, physical reconditioning and occupational therapy.

(10) Full use will be made of accepted medical treatment methods including drugs, individual and group psychotherapy and adjuvant therapy.

(11) Every effort will be made to supply an incentive for recovery.

b. *Procedures.*

(1) Treatment in combat zones is conducted at battalion aid stations; division clearing stations; designated clearing companies known as "exhaustion centers" and evacuation hospitals at Army level.

(2) Treatment in base areas is conducted in dispensaries; training center mental hygiene clinics; hospital outpatient departments; station and general hospitals; neuropsychiatric centers; and the reconditioning programs at convalescent centers.

c. *Results.*

(1) Combat cases: 40 to 60% return to full combat duty, 80 to 90% to duty of some sort.

(2) Base area cases: Approximately 50% return to full or limited duty.

5. *Disposition.* It is recognized that many individuals who are discharged from

the service because of psychoneurosis are able to adjust satisfactorily in civilian life. They are discharged because they are incapacitated for military service, and not because they are incapacitated for civilian life. In this respect they may be no different from many others who are discharged from the service for medical and surgical conditions and well able to get along satisfactorily in civilian pursuits. Military life makes demands upon individuals which are far greater than those incident to civilian existence. The stress of combat is such that anyone will develop a psychoneurosis if exposed long enough. There has, however, been a tendency to abuse medical channels for the disposition of military personnel who are ineffective for reasons other than sickness or injury. This has in great part been due to an unwillingness of command to dispose of individuals who are inapt, inadaptable and poorly motivated by administrative means. A more simplified means than now exists and a clear cut statement of policy concerning the disposition of such individuals is desirable.

6. *Prevention.* Control of the factors which determine the incidence of psychoneurosis rests within the province of command. Preventive measures carried on by the medical department, therefore, must be largely educative and advisory. They are along the following lines:

a. Education of line officers and enlisted men on the recognition, causes and prevention of psychoneurosis.

b. Motivation. To foster attitudes and beliefs conducive to effective military performance.

c. From a study of the causes of actual cases of psychoneurosis appearing among military personnel, make recommendations to the command concerning provision of incentive, job assignment, training, discipline, etc.

7. *Publicity.* There is an obvious need for the education of the public concerning the diagnosis of psychoneurosis. Roughly, 500,000 men have been rejected at induction stations with this diagnosis and almost 200,000 have already been discharged from the Army. These men face the problem of adjusting to civilian life. Unless the public misunderstanding concerning the meaning of this term is dispelled, readjustment to civilian life will be needlessly difficult and essential care such as provision for medical treatment and rehabilitation will not be made. It is the policy of this office to initiate and pursue public education, stressing the following points:

a. The term psychoneurosis does not mean insanity.

b. Psychoneurosis does not mean cowardice.

c. Most men with psychoneurosis are able to work and live a normal life.

d. The public must be prepared to encounter a considerable number of these cases.

8. *Current Trends.* A reprint of the article "Current Trends in Military Neuropsychiatry" by the Assistant Director of The Neuropsychiatry Consultants Division and The Chief of The Mental Hygiene Branch of this office is attached herewith as Tab F because it is pertinent to the present study. It outlines the present concepts of this office regarding the nature, mechanisms, treatment and prevention of psychoneuroses.

9. *Current Directives.* A brief summary of all directives concerning the past and present policies and procedures for the diagnosis, treatment and disposition of psychoneurotics and copies of the directives are appended as Tabs.

For The Surgeon General:

/s/ Robert J. Carpenter,
Lt. Colonel, Medical Corps,
Executive Officer.

MEMORANDUM FOR: The Assistant Chief of Staff, G–1 7 DECEMBER 1944
Through: The Commanding General, ASF
Subject: Psychoneuroses.

1. This memorandum has been prepared in compliance with the supplemental request from The Assistant Chief of Staff, G–1, dated 24 November 1944, for recommendations on the prevention of psychoneuroses among the personnel within the Army. Prevention is a major interest of psychiatry and it is the conviction of this office that it should make a major contribution to the mental health of the Army in this field, but this viewpoint in no way minimizes the magnitude of the treatment job.

Treatment needs are traditionally a function of the doctor and because it is an entirely intra-medical department problem, the field of treatment has been further developed than prevention. Preventive efforts necessarily involve the matter of policy in many of the branches of the War Department, particularly with G–1 and also in a major degree with G–3. Machinery for liaison between these groups and The Surgeon General's Office has never been sufficiently close for The Surgeon General to initiate assistance or express opinion on policies until they are in effect, and such a liaison could not exist unless by invitation from G–1 or G–3. Policies have been placed into effect, which we believe definitely influence mental health which might have been modified had they been evaluated from the point of view of their effect on mental health.

It should be understood that medicine, and especially psychiatry, is fundamentally interested in the normal as well as the pathological. It is believed that in those instances where policy affects the motivation, the feelings or the behavior of people that psychiatry might make a contribution as to the possible effect on the mental health of such policy. Such an opinion would represent one and only one perspective of any particular policy, and it is not presumed that it would or should be the final basis for a decision.

2. *Combat.*

a. Recommendations designed to decrease the incidence of psychoneurosis in combat have already been submitted. These cover tactical rotation, tour of combat duty, privileges for combat soldiers, replacement policy, training, classification, abuse of medical channels for disposition and leadership. Reference is made to Memorandum to The Assistant Chief of Staff for G–1 from The Surgeon General, Subject: "Prevention of Manpower Loss From Psychiatric Disorders," dated 16 September 1944.

b. Colonel William C. Menninger, Director, Neuropsychiatric Consultants Division, Office of The Surgeon General, recently conducted a similar study in the European Theater of Operations. A copy of his report is attached. The findings of this report corroborate those presented in the memorandum referred to above * * *.

3. *Motivation.*

a. Insufficient realization by the average soldier of the degree to which the enemy threatened his personal welfare is believed to have been a basic cause for the high incidence of psychoneurosis among military personnel. It is believed that the attempts to motivate personnel would have been more effective if:

(1) More information indicating enemy intent and ability to harm the United States had been presented to military personnel.

(2) The command had made greater use of communication media in the dissemination of information.

(3) The agencies and programs concerned with motivation of personnel had received (1) earlier and more complete knowledge of existing War Department problems, plans and policies; (2) more effective administrative support in providing program time and qualified personnel.

4. *Discharge Methods.*

a. *Enlisted Personnel.*

(1) Administrative disposition of individuals who are inapt and unadaptable is frequently not accomplished because of the difficulties inherent in the present system and because of the reluctance of Commanding Officers to use this method. As a result, some of these individuals develop psychoneuroses from being kept in situations which are beyond their capabilities and others from the confusion arising out of repeated hospitalizations.

(2) In the past, the number of men who have been discharged by CDD has reflected preponderantly the Army's manpower needs rather than the occurrence of disabling physical defects. In general, an individual should not be discharged for disability when he is capable of performing limited service.

(a) Many men who are on limited service for physical defects are disabled only to the extent that they are not capable of performing full combat service. They are not truly disabled for limited service or for civilian life.

(b) Some men are on limited service, not because of existing defects, but because it is recognized that they would develop disabilities if exposed to combat service. A good example of this is an individual with neurotic tendencies.

(3) There are many men who are relatively ineffective for reasons other than health, but past policy has resulted in the labeling of these individuals with medical diagnosis, warranted or not, in order to effect their discharge. In connection with this, it would appear advisable to have a clear-cut expression of policy of the War Department concerning the abuse of medical channels in discharging personnel from the service.

b. *Officers.*

(1) The incidence of psychoneurosis in officers could undoubtedly be reduced if a more simple procedure than now exists were available for returning ineffective officers to civilian life. Commanding Officers reluctant to undertake the time-consuming and often unsuccessful reclassification procedures frequently make attempts to have ineffective officers discharged through medical channels. It should also be possible to more easily reduce the grade and responsibility of officers to a point where they could function without anxiety when they are assigned to positions which are beyond their capabilities.

c. *General Effects of the Type of Discharge Used.*

(1) The present policy of controlling the size of the Army by discharging large numbers of relative noneffectives by Section II or Section X, AR 615–360, 25 May 1944 (now AR 615–361 and AR 615–365) results in an increased incidence of psychoneurosis and tends to decrease the effectiveness of military personnel in general. This is because both of these discharges are honorable and because they imply a medical disability which is frequently not present. Unfortunately, a large percentage of military personnel sincerely believe that they could do more for the war effort as civilians than as soldiers. If honorable discharges are given to those who have been non-effective, and if in addition a medical disability is implied when it is not actually present, then an incentive to do effective duty is removed.

5. *Personnel.*

a. In view of the shortage of trained psychiatrists, the use of auxiliary personnel in the prevention and treatment of neuropsychiatric disorders is essential. Difficulties have been encountered in obtaining this personnel as a result of inadequate allotments of personnel to Medical Department installations and the absence of Tables of Organization in the case of Division Psychiatrists and Mental Hygiene Clinics.

6. *Classification and Assignment.*

a. When an individual is assigned to a job which he is unable to do, he may react by developing a psychoneurosis. A considerable percentage of individuals with

psychoneurosis seen in Army hospitals would either not have developed their sickness or would have been able to continue in spite of it had they been assigned to less arduous jobs or jobs of a different type.

b. The degree to which medical judgment can be used to advantage either in formulation of policy or in administration of classification and assignment is not entirely clear, but would appear to warrant further study.

c. The dangers inherent in utilization of choice in job assignment are obvious. However were its adoption feasible, it is believed it would offer an important potential means of lowering the incidence of psychoneurosis.

7. *Utilization of Manpower.*

a. Elementary knowledge of human behavior indicates a wide variance in the mental and physical capabilities of men. These capabilities are the deciding factor on whether a man may be an executive or a clerk, an elevator operator or a longshoreman. There are many reasons why this elementary knowledge has not been effectively utilized in the organization of the Army. There is, however, a large group of men with limited mental capacity, but good physical condition, who, because of their mental limitations, cannot make effective combat soldiers.

b. A second group of handicapped individuals are the neuropsychiatric combat veterans, who have, to some degree, become non-effective for combat, but in whom we could prevent the further development of maladjustment if they could be appropriately and adequately assigned in noncombat positions. Not only could they be rehabilitated, but they would not be included as neuropsychiatric casualties to be discharged. If such assignment possibilities were available, it would be a step toward the prevention of the development or aggravation of neurotic symptomatology. In the best utilization of manpower, adequate provisions should be made for the appropriate assignment of veterans returned on rotation. Another step, the retraining of selected neuropsychiatric cases, although not actually reducing the incidence of neuropsychiatric difficulty as it occurs in the Army, would reduce the incidence of the number of men discharged for this disability. Such a retraining plan should follow along the lines of the experiment conducted at Belvoir, Aberdeen and Lee in the spring and summer of 1944.

8. *Leadership.*

a. As mentioned in previous memoranda, the quality of unit leadership is an important factor in determining the incidence of psychoneurosis. This office is not sufficiently acquainted with the leadership system to make specific comments or recommendations as to how it might be improved. Aspects of the problem * * * appear to merit further study * * *.

9. *Training.*

a. There is a high incidence of neuropsychiatric casualties during the soldier's first three months in the Army, at which time they are in basic training. Some of these maladjustments seem to be definitely related to training methods. An individual with a low intellectual capacity cannot effectively compete with men of superior, or, often even with average intelligence, and definitely cannot absorb training at a rapid rate. His only defense is the development of personality difficulties. Another factor affecting the soldier's adjustment in the situation is the temporary nature of the organization which he joins in the basic training camp. His officers are temporary and he knows that he is temporary, with the result that no close loyalties can be formed. Too often, the soldier goes out as a replacement and is assigned to a combat unit with no opportunity to become acquainted with the unit and entirely separated from any of the men with whom he trained.

10. *Mental Hygiene Lectures.*

a. On the assumption that a knowledge of elementary principles of mental hygiene were equally as important for Command to know as first aid, War Department Circular 48, dated 3 February 1944, prescribed six hours of lectures for officers and

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three for enlisted men. It is believed that these are not being given in most camps and posts although they have a high preventive value.

11. *Restrictions by the Joint Security Board on Information Relative to Neuropsychiatry.*

a. Because of existing restrictions imposed by the Joint Security Board, it has not been possible to publicly present the size and thus the actual status of the neuropsychiatric problems in the Army. Free utilizations of figures (without identifying units) would enable one to much more forcefully present and emphasize the importance of the problem with its attendant advantage as an aid to prevention.

12. *Recommendations.* In order to prevent psychoneurosis in military personnel, it is recommended that:

Combat:

1. In addition to the recommendations submitted previously,

a. The tour of combat duty for combat infantrymen as recommended previously be given an experimental trial on a limited scale.

b. Length of time of infantry combat duty be credited by authorization of a star or mark on the combat infantryman's badge for each thirty days of combat (or some such period).

Motivation:

2. The command itself makes more direct use of communication media in dealing with attitudinal and motivational problems in military personnel by:

a. Military leaders addressing personnel by radio, military press, motion pictures, etc.

b. Taking a more active part in the selection of subjects and formulating content of informational programs.

3. A standard operating procedure be made for War Department agencies to confer with the Information and Education Division on problems, plans, and policies which have a potential effect on the attitudes and beliefs of military personnel.

Discharge Methods:

4. A simplified procedure for disposing of inapt and unadaptable individuals be adopted.

5. The criteria for disability discharges (CDD) remain fairly rigid and not be subject to variation in relation to manpower needs.

6. When a surplus of personnel exists in the Army and it is desired to discharge the relatively ineffective group who are not sick, criteria other than medical be used to accomplish such discharges and that clear distinction be made between individuals who are ineffective by reason of sickness and those who are ineffective for other reasons.

7. A method which will facilitate the disposition of ineffective officers be adopted.

8. Consideration be given to the type of discharge used in view of its effect on the incidence of psychoneurosis and performance of effective duty.

Personnel:

9. Consideration be given to the training of psychiatric social workers.

10. Personnel allotments to hospitals be increased to provide for the assignment of psychiatric social workers and clinical psychologists.

11. Tables of Organization be provided to Division Psychiatrists and Mental Hygiene Clinics in training centers.

Classification and Assignment:

12. The advisability of extending the use of medical judgment in classification and job assignment be considered.

13. The possibility of introducing choice in job assignment be considered.

Utilization of Manpower:

14. Consideration be given to the more effective utilization of the large group of limited capacity personnel by segregation in special units for assignment to duties commensurate with their limited capacity.

15. Assignments be provided for the effective utilization of neuropsychiatric combat casualties in the theater of operations.

16. Soldiers being returned from combat service overseas should not be assigned as trainees in basic training and that special consideration be given as to how they can best be utilized.

17. Further consideration be given to the plan for the retraining of selected psychoneurotic patients.

Training:

18. Consideration be given to establishing separate training schedules of graded difficulty, commensurate with widely divergent capacities to learn.

19. Consideration be given to developing specific ways and means of aiding the soldier in his initial adjustment from civilian life in the basic training centers.

20. Replacements who have trained together should enter combat units together in at least groups of two and three instead of being assigned individually.

Mental Hygiene Lectures:

21. War Department Circular 48 should be implemented so that it is effectively carried out throughout the Army.

B.P.R. Restrictions:

22. The policy as enunciated by the Joint Security Board on the release of information relative to the neuropsychiatric problem be liberalized.

/s/ NORMAN T. KIRK,
Maj. Gen., USA,
The Surgeon General.

APPENDIX F

Calendar of Significant Events

1914	
16 January	to 3 October 1918, Maj. Gen. William C. Gorgas, The Surgeon General.
1917	
19 July	The Surgeon General authorizes establishment of a Neurology and Psychiatry Division in the Office of the Surgeon General.
1918	
15 July	General Pershing sends his famous telegram to the Chief of Staff, concerning ineffectuals sent to AEF overseas.
30 November	Neurology and Psychiatry Section under Medical Service.
1920	
1 September	Medical Field Service School established at Carlisle Barracks, Pa. (Moved to Fort Sam Houston, Tex., as the Army Medical Service School, 1945.)
1939	
1 June	to 31 May 1943, Maj. Gen. James C. Magee, The Surgeon General.
1 September	Germany invades Poland.
1940	
10 May	Germany invades the Netherlands, Belgium, and Luxembourg. Churchill becomes British Prime Minister.
1 August	Col. Patrick J. Madigan, MC, appointed psychiatrist in the Surgeon General's Office. (Served until 15 Aug. 1942.)
16 September	Selective Training and Service Act adopted.
1 November	Position of division psychiatrist omitted from T/O 8–21, Medical Regiment.
1941	
22 June	Germany attacks U.S.S.R.
1 December	Enlisted psychologists authorized (MOS 289).
7 December	Japan attacks Pearl Harbor.
8 December	United States and Great Britain declare war on Japan.
10–11 December	United States declares war on Germany and Italy. Germany and Italy declare war on the United States.
22 December	Japanese bomb Manila.
1942	
February	Neuropsychiatry Branch established in the Surgeon General's Office with Colonel Madigan as chief.
9 April	U.S. Army Forces on Bataan surrender.
10 April	Lt. Col. Malcolm J. Farrell, MC, appointed as Assistant Chief of Neuropsychiatry Branch (later Neuropsychiatry Consultants Division). (Served until 15 Sept. 1945.)

28 May	Letter, The Surgeon General to Commanding General, Services of Supply (later Army Service Forces), requesting approval and appointment of consultants to the 9 corps areas (later service commands).
3–4 June	Battle of Midway.
28 July	Letter, The Surgeon General to Commanding General (all service commands), establishing the policy governing the activities of service command consultants.
7 August	U.S. Marines land on Guadalcanal.
17 August	to 10 November 1943, Col. Roy D. Halloran, MC, Chief Consultant in Neuropsychiatry to The Surgeon General.
24 October	Psychiatrists approved for Mental Hygiene Consultation Centers.
7–8 November	U.S. Army Forces land in North Africa.
20 December	School of Military Neuropsychiatry established at Lawson General Hospital, Atlanta, Ga., with Col. William C. Porter, MC, as Director.
1943	
14–23 January	Casablanca Conference.
23 January	British Eighth Army enters Tripoli.
2 February	German forces surrender at Stalingrad.
March	Public Law No. 10, 78th Congress, removes many restrictions on line-of-duty status.
24 March	Lt. John W. Appel, MC, appointed to the Neuropsychiatry Branch for program in preventive psychiatry.
22 April	Maj. Walter E. Barton, MC, appointed to the Neuropsychiatry Branch, for treatment program; reassigned to Reconditioning Division, 19 August 1943.
1 June	to 31 May 1947, Maj. Gen. Norman T. Kirk, The Surgeon General. (Retired 31 July 1947.)
9 July	Invasion of Sicily.
14 July	WD Circular No. 161, opens door for easy discharge and eliminates "Limited Service" category.
31 July	WD Circular No. 176, permits administrative discharge "for the convenience of the Government."
5 August	General Patton orders "cowards" to be excluded from hospitals.
10 August	"Patton slapping incident."
21 August	First neuropsychiatric directive issued in an oversea army (Fifth U.S. Army).
3 September	Invasion of southern Italy.
October	The School of Military Neuropsychiatry moves to Mason General Hospital, Brentwood, Long Island, N.Y. (Closes on 22 December 1945.)
3 October	Maj. William H. Everts, MC, transferred to the Neuropsychiatry Branch as Chief of Neurology.
18 October	MOS 263 obtained for enlisted psychiatric social workers.
18 October	Medical survey program of Selective Service System published as "Selective Service System Medical Circular No. 4."
9 November	WD Circular No. 290 restores position of division psychiatrist to the table of organization of infantry units.

10 November	Colonel Halloran dies suddenly.
11 November	WD Circular No. 293 rescinds WD Circular No. 161.
3 December	Circular Letter No. 194, Office of The Surgeon General, U.S. Army, subject: Disposition of Neuropsychiatric Disorders. (This is the first official letter by the Surgeon General's Office on conservation manpower.)
10 December	Lt. Col. William C. Menninger, MC, appointed as Chief Consultant in Neuropsychiatry and Chief of the Neuropsychiatry Branch.
1944	
1 January	Neuropsychiatry Branch made a separate division of The Surgeon General's Office.
22 January	Fifth U.S. Army makes amphibious assault landing at Anzio.
22 February	TB MED 12, "Lecture Outlines for Officers on Personnel Adjustment Problems," issued.
15 March	TB MED 21, "Lecture Outlines for Enlisted Men on Personal Adjustment Problems," issued.
12 May	ASF Circular No. 138 returned to The Surgeon General the responsibility for proper assignment of Medical Corps officers and nurses.
4 June	Fifth U.S. Army enters Rome.
6 June	D-day; Allied invasion of Normandy.
July	Lt. Gen. Brehon B. Somervell, Commanding General, ASF, directs The Surgeon General to train sufficient psychiatrists and psychologists to meet the overall need of the Army (Service Command Conference, Fort Leonard Wood, Mo.).
3 July	Commissioned psychologists authorized.
21 July	U.S. Forces occupy Guam.
25 August	Neuropsychiatry Consultants Division created as a separate division directly responsible to the Deputy Surgeon General and the Executive Officer.
25 August	Paris is liberated.
12 September	WD Circular No. 370, section II, again opens door for easy discharge.
15 September	Maj. Manfred S. Guttmacher, MC, assigned to Neuropsychiatry Consultants Division, for mental hygiene consultation services.
21 September	TB MED 94, "Neuropsychiatry for the General Medical Officer," issued.
23-26 October	Battle of Leyte Gulf.
7 December	Memorandum for Assistant Chief of Staff, G–1, from The Surgeon General, subject: Psychoneuroses. This marks the beginning of acceptance by G–1 and the War Department of command responsibility for ineffectife soldiers. (See appendix E, pp. 807–821.)
16 December	Germans begin Battle of the Bulge.
1945	
9 January	U.S. Forces begin offensive on Luzon, Philippines.
3 February	U.S. Forces attack Manila.
19 February	U.S. Forces attack Iwo Jima.
1 April	U.S. Forces assault Okinawa.

12 April	President Franklin D. Roosevelt dies; Vice President Harry S. Truman sworn in as President.
27 April	ASF Circular No. 151 directs rotation of personnel with no previous oversea duty.
7 May	Germany surrenders.
8 May	V–E Day (Victory in Europe).
July	Lt. Col. Frederick R. Hanson, MC, assigned to the Office of the Assistant Chief of Staff, G–1. (This appointment signals the serious attempt of the War Department to improve the manpower crisis.)
1 July	Psychiatric Social Work Section established in the Neuropsychiatry Consultants Division, with Maj. Daniel E. O'Keefe, MAC, appointed as chief, while on loan from the Adjutant General's Office.
6 August	First atomic bomb dropped on Hiroshima.
9 August	Second atomic bomb dropped on Nagasaki.
14 August	Japan surrenders unconditionally.
1 September	Clinical Psychology becomes a branch of the Neuropsychiatry Consultants Division.
2 September	V–J Day (Victory over Japan). Japan signs surrender terms.
10 September	Psychiatric Social Work Section established in the Neuropsychiatry Consultants Division.
16 November	Report by Maj. Gen. F. H. Osborne to Chief of Staff, on training of Reserves.
1946	
10 January	The School of Military Neuropsychiatry authorized to move to Brooke Army Medical Center, Fort Sam Houston, Tex.
12 January	WD Circular No. 12, Section II, "Appointment of Consultants." (This is the first circular to specifically authorize The Surgeon General to appoint professional consultants.)
4 April	WD Circular No. 101, Section III, outlines the functions of consultants.
27 May	Doolittle's report to the Secretary of War on officer-enlisted man's relationships.
1 June	The School of Military Neuropsychiatry moves to Brooke Army Medical Center.

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